United Nations A/HRC/38/35

General Assembly

Distr.: General
6 April 2018

Original: English

Human Rights Council
Thirty-eighth session
18 June–6 July 2018
Agenda item 3
Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

Report of the Special Rapporteur on the promotion and protection of the right to freedom of opinion and expression

Note by the Secretariat

The Secretariat has the honour to transmit to the Human Rights Council the report of the Special Rapporteur on the promotion and protection of the right to freedom of opinion and expression, David Kaye, pursuant to Council resolution 34/18. In his report the Special Rapporteur addresses the regulation of user-generated online content. He recommends that States ensure an enabling environment for online freedom of expression and that companies apply human rights standards at all stages of their operations. Human rights law gives companies the tools to articulate their positions in ways that respect democratic norms and counter authoritarian demands. At a minimum, companies and States should pursue radically improved transparency, from rule-making to enforcement of the rules, to ensure user autonomy as individuals increasingly exercise fundamental rights online.

GE.18-05436(E)
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Contents

		Page
I.	Introduction	3
II.	Legal framework	3
	A. State obligations	4
	B. Company responsibilities	5
III.	Key concerns with content regulation	6
	A. Government regulation	6
	B. Company moderation of content	8
IV.	Human rights principles for company content moderation	14
	A. Substantive standards for content moderation	15
	B. Processes for company moderation and related activities	16
V.	Recommendations	19

I. Introduction

1. Early in the digital age, John Perry Barlow declared that the Internet would usher in "a world where anyone, anywhere may express his or her beliefs, no matter how singular, without fear of being coerced into silence or conformity".[1] Although the Internet remains history's greatest tool for global access to information, such online evangelism is hard to find today. The public sees hate, abuse and disinformation in the content users generate. Governments see terrorist recruitment or discomfiting dissent and opposition. Civil society organizations see the outsourcing of public functions, like protection of freedom of expression, to unaccountable private actors. Despite taking steps to illuminate their rules and government interactions, the companies remain enigmatic regulators, establishing a kind of "platform law" in which clarity, consistency, accountability and remedy are elusive. The United Nations, regional organizations and treaty bodies have affirmed that offline rights apply equally online, but it is not always clear that the companies protect the rights of their users or that States give companies legal incentives to do so.

2. In the present report the Special Rapporteur proposes a framework for the moderation of user-generated online content that puts human rights at the very centre.[2] He seeks to answer basic questions: What responsibilities do companies have to ensure that their platforms do not interfere with rights guaranteed under international law? What standards should they apply to content moderation? Should States regulate commercial content moderation and, if so, how? The law expects transparency and accountability from States to mitigate threats to freedom of expression. Should we expect the same of private actors? What do the processes of protection and remedy look like in the digital age?

3. Previous reports have addressed some of these questions.[3] The present report focuses on the regulation of user-generated content, principally by States and social media companies but in a way that is applicable to all relevant actors in the information and communications technology (ICT) sector. The Special Rapporteur outlines the applicable human rights legal framework and describes company and State approaches to content regulation. He proposes standards and processes that companies should adopt to regulate content in accordance with human rights law.

4. Research into the companies' terms of service, transparency reporting and secondary sources provided the initial basis for the report. Calls for comments generated 21 submissions from States and 29 from non-State actors (including 1 company submission). The Special Rapporteur visited several companies in Silicon Valley and held conversations with others in an effort to understand their approaches to content moderation.[4] He benefited from civil society consultations held in Bangkok and Geneva in 2017 and 2018 and online discussions with experts in Latin America, the Middle East and North Africa and sub-Saharan Africa in 2018.[5]

II. Legal framework

5. The activities of companies in the ICT sector implicate rights to privacy, religious freedom and belief, opinion and expression, assembly and association, and public participation, among others. The present report focuses on freedom of expression while

[1] John Perry Barlow, A Declaration of the Independence of Cyberspace, 8 February 1996.

[2] "Moderation" describes the process by which Internet companies determine whether user-generated content meets the standards articulated in their terms of service and other rules.

[3] A/HRC/35/22 and A/HRC/32/38.

[4] The Special Rapporteur visited the headquarters of Facebook, Github, Google, Reddit and Twitter and held conversations with representatives of Yahoo/Oath, Line and Microsoft. He also visited the non-profit Wikimedia Foundation. He hopes to visit companies in Beijing, Moscow, Seoul and Tokyo in work related to the present report.

[5] The Special Rapporteur wishes to thank his legal adviser, Amos Toh, and students at the International Justice Clinic at the University of California, Irvine, School of Law.

acknowledging the interdependence of rights, such as the importance of privacy as a gateway to freedom of expression.[6] Article 19 of the International Covenant on Civil and Political Rights provides globally established rules, ratified by 170 States and echoing the Universal Declaration of Human Rights, guaranteeing "the right to hold opinions without interference" and "the right to seek, receive and impart information and ideas of all kinds, regardless of frontiers" and through any medium.[7]

A. State obligations

6. Human rights law imposes duties on States to ensure enabling environments for freedom of expression and to protect its exercise. The duty to ensure freedom of expression obligates States to promote, *inter alia*, media diversity and independence and access to information.[8] Additionally, international and regional bodies have urged States to promote universal Internet access.[9] States also have a duty to ensure that private entities do not interfere with the freedoms of opinion and expression.[10] The Guiding Principles on Business and Human Rights, adopted by the Human Rights Council in 2011, emphasize in principle 3 State duties to ensure environments that enable business respect for human rights.[11]

7. States may not restrict the right to hold opinions without interference. Per article 19 (3) of the Covenant, State limitations on freedom of expression must meet the following well-established conditions:

- *Legality*. Restrictions must be "provided by law". In particular, they must be adopted by regular legal processes and limit government discretion in a manner that distinguishes between lawful and unlawful expression with "sufficient precision". Secretly adopted restrictions fail this fundamental requirement.[12] The assurance of legality should generally involve the oversight of independent judicial authorities.[13]
- *Necessity and proportionality*. States must demonstrate that the restriction imposes the least burden on the exercise of the right and actually protects, or is likely to protect, the legitimate State interest at issue. States may not merely assert necessity but must demonstrate it, in the adoption of restrictive legislation and the restriction of specific expression.[14]
- *Legitimacy*. Any restriction, to be lawful, must protect only those interests enumerated in article 19 (3): the rights or reputations of others, national security or public order, or public health or morals. Restrictions designed to protect the rights of others, for instance, include "human rights as recognized in the Covenant and more generally in international human rights law".[15] Restrictions to protect rights to privacy, life, due process, association and participation in public affairs, to name a few, would be legitimate when demonstrated to meet the tests of legality and necessity. The Human Rights Committee cautions that restrictions to protect "public

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[6] See A/HRC/29/32, paras. 16–18.

[7] See also African Charter on Human and Peoples' Rights, art. 9; American Convention on Human Rights, art. 13; Convention for the Protection of Human Rights and Fundamental Freedoms, art. 10. See also Centro de Estudios en Libertad de Expresión y Acceso a la Información submission.

[8] Joint Declaration on Freedom of Expression and "Fake News", Disinformation and Propaganda, 3 March 2017, sect. 3. See also Human Rights Committee, general comment No. 34 (2011) on the freedoms of opinion and expression, paras. 18 and 40; A/HRC/29/32, para. 61 and A/HRC/32/38, para. 86.

[9] See Human Rights Council, resolution 32/13, para. 12; Office of the Special Rapporteur for Freedom of Expression of the Inter-American Commission on Human Rights, *Standards for a Free, Open and Inclusive Internet* (2016), para. 18.

[10] See general comment No. 34, para. 7.

[11] A/HRC/17/31.

[12] Ibid. para. 25; A/HRC/29/32.

[13] Ibid.

[14] See general comment No. 34, para. 27.

[15] Ibid., para. 28.

morals" should not derive "exclusively from a single tradition", seeking to ensure that the restriction reflects principles of non-discrimination and the universality of rights.[16]

8. Restrictions pursuant to article 20 (2) of the Covenant — which requires States to prohibit "advocacy of national, racial or religious hatred that constitutes incitement to discrimination, hostility or violence" — must still satisfy the cumulative conditions of legality, necessity and legitimacy.[17]

B. Company responsibilities

9. Internet companies have become central platforms for discussion and debate, information access, commerce and human development.[18] They collect and retain the personal data of billions of individuals, including information about their habits, whereabouts and activities, and often claim civic roles. In 2004, Google promoted its ambition to do "good things for the world even if we forgo some short term gains".[19] Facebook's founder has proclaimed a desire to "develop the social infrastructure to give people the power to build a global community that works for all of us".[20] Twitter has promised policies that "improve — and do not detract from — a free and global conversation".[21] VKontakte, a Russian social media company, "unites people all over the world", while Tencent reflects the language of the Government of China when noting its aims to "help build a harmonious society and to become a good corporate citizen".[22]

10. Few companies apply human rights principles in their operations, and most that do see them as limited to how they respond to government threats and demands.[23] However, the Guiding Principles on Business and Human Rights establish "global standard[s] of expected conduct" that should apply throughout company operations and wherever they operate.[24] While the Guiding Principles are non-binding, the companies' overwhelming role in public life globally argues strongly for their adoption and implementation.

11. The Guiding Principles establish a framework according to which companies should, at a minimum:

(a) Avoid causing or contributing to adverse human rights impacts and seek to prevent or mitigate such impacts directly linked to their operations, products or services by their business relationships, even if they have not contributed to those impacts (principle 13);

(b) Make high-level policy commitments to respect the human rights of their users (principle 16);

(c) Conduct due diligence that identifies, addresses and accounts for actual and potential human rights impacts of their activities, including through regular risk and impact assessments, meaningful consultation with potentially affected groups and other stakeholders, and appropriate follow-up action that mitigates or prevents these impacts (principles 17–19);

(d) Engage in prevention and mitigation strategies that respect principles of internationally recognized human rights to the greatest extent possible when faced with conflicting local law requirements (principle 23);

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[16] Ibid., para. 32.

[17] Ibid., para. 50. See also A/67/357.

[18] See, for example, Supreme Court of the United States, *Packingham v. North Carolina*, opinion of 19 June 2017; European Court of Human Rights, *Times Newspapers Ltd. (Nos. 1 and 2) v. The United Kingdom* (application Nos. 3002/03 and 23676/03), judgment of 10 March 2009, para. 27.

[19] Securities Registration Statement (S-1) under the Securities Act of 1933, 18 August 2004.

[20] Mark Zuckerberg, "Building global community", Facebook, 16 February 2017.

[21] Twitter, S-1 Registration Statement, 13 October 2013, pp. 91–92.

[22] VKontakte, company information; Tencent, "About Tencent".

[23] Danish Institute for Human Rights submission. Cf. Yahoo/Oath submission, 2016.

[24] Guiding Principles, principle 11.

(e) Conduct ongoing review of their efforts to respect rights, including through regular consultation with stakeholders, and frequent, accessible and effective communication with affected groups and the public (principles 20–21);

(f) Provide appropriate remediation, including through operational-level grievance mechanisms that users may access without aggravating their "sense of disempowerment" (principles 22, 29 and 31).

III. Key concerns with content regulation

12. Governments seek to shape the environment in which companies moderate content, while the companies predicate individual access to their platforms on user agreement with terms of service that govern what may be expressed and how individuals may express it.

A. Government regulation

13. States regularly require companies to restrict manifestly illegal content such as representations of child sexual abuse, direct and credible threats of harm and incitement to violence, presuming they also meet the conditions of legality and necessity.[25] Some States go much further and rely on censorship and criminalization to shape the online regulatory environment.[26] Broadly worded restrictive laws on "extremism", blasphemy, defamation, "offensive" speech, "false news" and "propaganda" often serve as pretexts for demanding that companies suppress legitimate discourse.[27] Increasingly, States target content specifically on online platforms.[28] Other laws may interfere with online privacy in ways that deter the exercise of freedom of opinion and expression.[29] Many States also deploy tools of disinformation and propaganda to limit the accessibility and trustworthiness of independent media.[30]

14. *Liability protections*. From early in the digital age, many States adopted rules to protect intermediaries from liability for the content third parties publish on their platforms. The European Union e-commerce directive, for instance, establishes a legal regime to protect intermediaries from liability for content except when they go beyond their role as a "mere conduit", "cache" or "host" of information provided by users.[31] Section 230 of the United States Communications Decency Act generally provides immunity for providers of "interactive computer service[s]" that host or publish information about others, but this has since been curtailed.[32] The intermediary liability regime in Brazil requires a court order to restrict particular content,[33] while the intermediary liability regime in India establishes a "notice and takedown" process that involves the order of a court or similar adjudicative

[25] Ireland has established co-regulatory mechanisms with companies to restrict illegal child sexual abuse material: Ireland submission. Many companies rely on a picture recognition algorithm to detect and remove child pornography: submissions by Open Technology Institute, p. 2 and ARTICLE 19, p. 8.

[26] See A/HRC/32/38, paras. 46–47. On Internet shutdowns, see A/HRC/35/22, paras. 8–16 and examples of communications of the Special Rapporteur: Nos. UA TGO 1/2017, UA IND 7/2017 and AL GMB 1/2017.

[27] Communication Nos. OL MYS 1/2018, UA RUS 7/2017, UA ARE 7/2017, AL BHR 8/2016, AL SGP 5/2016 and OL RUS 7/2016. Azerbaijan prohibits propaganda of terrorism, religious extremism and suicide: Azerbaijan submission.

[28] See communication Nos. OL PAK 8/2016 and OL LAO 1/2014; Association for Progressive Communications, *Unshackling Expression: A Study on Laws Criminalising Expression Online in Asia*, GISWatch 2017 Special Edition.

[29] A/HRC/29/32.

[30] See, for example, Gary King, Jennifer Pan and Margaret E. Roberts, "How the Chinese Government fabricates social media posts for strategic distraction, not engaged argument", *American Political Science Review*, vol. 111, No. 3 (2017), pp. 484–501.

[31] Directive No. 2000/31/EC of the European Parliament and of the Council of 8 June 2000.

[32] 47 United States Code § 230. See also the Allow States and Victims to Fight Online Sex Trafficking Act (H.R. 1865).

[33] *Marco Civil da Internet*, federal law 12.965, arts. 18–19.

body.[34] The 2014 Manila Principles on Intermediary Liability, developed by a coalition of civil society experts, identify essential principles that should guide any intermediary liability framework.

15. *Imposition of company obligations*. Some States impose obligations on companies to restrict content under vague or complex legal criteria without prior judicial review and with the threat of harsh penalties. For example, the Chinese Cybersecurity Law of 2016 reinforces vague prohibitions against the spread of "false" information that disrupts "social or economic order", national unity or national security; it also requires companies to monitor their networks and report violations to the authorities.[35] Failure to comply has reportedly led to heavy fines for the country's biggest social media platforms.[36]

16. Obligations to monitor and rapidly remove user-generated content have also increased globally, establishing punitive frameworks likely to undermine freedom of expression even in democratic societies. The network enforcement law (*NetzDG*) in Germany requires large social media companies to remove content inconsistent with specified local laws, with substantial penalties for non-compliance within very short time frames.[37] The European Commission has even recommended that member States establish legal obligations for active monitoring and filtering of illegal content.[38] Guidelines adopted in 2017 in Kenya on the dissemination of social media content during elections require platforms to "pull down accounts used in disseminating undesirable political contents on their platforms" within 24 hours.[39]

17. In the light of legitimate State concerns such as privacy and national security, the appeal of regulation is understandable. However, such rules involve risks to freedom of expression, putting significant pressure on companies such that they may remove lawful content in a broad effort to avoid liability. They also involve the delegation of regulatory functions to private actors that lack basic tools of accountability. Demands for quick, automatic removals risk new forms of prior restraint that already threaten creative endeavours in the context of copyright.[40] Complex questions of fact and law should generally be adjudicated by public institutions, not private actors whose current processes may be inconsistent with due process standards and whose motives are principally economic.[41]

18. *Global removals*. Some States are demanding extraterritorial removal of links, websites and other content alleged to violate local law.[42] Such demands raise serious

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[34] Supreme Court of India, *Shreya Singhal v. Union of India*, decision of 24 March 2015.

[35] Articles 12 and 47, Human Rights in China submission, 2016, p. 12. For comments on an earlier draft of the Cybersecurity Law, see communication No. OL CHN 7/2015. See also Global Voices, "Netizen Report: Internet censorship bill looms large over Egypt", 16 March 2018; Republic of South Africa, Films and Publications Amendment Bill (B 61—2003).

[36] PEN America, *Forbidden Feeds: Government Controls on Social Media in China* (2018), p. 21.

[37] Act to Improve Enforcement of the Law in Social Networks (Network Enforcement Act), July 2017. See communication No. OL DEU 1/2017.

[38] European Commission, recommendation on measures to effectively tackle illegal content online (last updated: 5 March 2018).

[39] See communication No. OL KEN 10/2017; Javier Pallero, "Honduras' new bill threatens to curb online speech", Access Now, 12 February 2018.

[40] See European Commission, Proposal for a Directive of the European Parliament and of the Council on Copyright in the Digital Single Market, COM (2016) 593 final, art. 13; Daphne Keller, "Problems with filters in the European Commission's platforms proposal", Stanford Law School Center for Internet and Society, 5 October 2017; Fundación Karisma submission, 2016, pp. 4–6.

[41] Under European Union law, search engines are required to determine the validity of claims brought under the "right to be forgotten" framework. European Court of Justice, *Google Spain v. Agencia Española de Protección de Datos and Mario Costeja González* (case C-131/12), judgment (Grand Chamber) of 13 May 2014; submissions by ARTICLE 19, pp. 2–3 and Access Now, pp. 6–7; Google, "Updating our 'right to be forgotten' Transparency Report"; Theo Bertram and others, *Three Years of the Right to be Forgotten* (Google, 2018).

[42] See, for example, PEN America, *Forbidden Feeds*, pp. 36–37; Supreme Court of Canada, *Google Inc. v. Equustek Solutions Inc.*, judgment of 28 June 2017; European Court of Justice, *Google Inc. v.*

concern that States may interfere with the right to freedom of expression "regardless of frontiers". The logic of these demands would allow censorship across borders, to the benefit of the most restrictive censors. Those seeking removals should be required to make such requests in every jurisdiction where relevant, through regular legal and judicial process.

19. *Government demands not based on national law*. Companies distinguish between requests for the removal of allegedly illegal content submitted through regular legal channels and requests for removal based on the companies' terms of service.[43] (Legal removals generally apply only in the requesting jurisdiction; terms of service removals generally apply globally.) State authorities increasingly seek content removals outside of legal process or even through terms of service requests.[44] Several have established specialized government units to refer content to companies for removal. The European Union Internet Referral Unit, for instance, "flag[s] terrorist and violent extremist content online and cooperat[es] with online service providers with the aim of removing this content".[45] Australia also has similar referral mechanisms.[46] In South-East Asia, parties allied with Governments reportedly attempt to use terms of service requests to restrict political criticism.[47]

20. States also place pressure on companies to accelerate content removals through non-binding efforts, most of which have limited transparency. A three-year ban on YouTube in Pakistan compelled Google to establish a local version susceptible to government demands for removals of "offensive" content.[48] Facebook and Israel reportedly agreed to coordinate efforts and staff to monitor and remove "incitement" online. The details of this agreement were not disclosed, but the Israeli Minister of Justice claimed that between June and September 2016, Facebook granted nearly all government requests for removal of "incitement".[49] Arrangements to coordinate content actions with State input exacerbate concerns that companies perform public functions without the oversight of courts and other accountability mechanisms.[50]

21. The 2016 European Union Code of Conduct on countering illegal hate speech online involves agreement between the European Union and four major companies to remove content, committing them to collaborate with "trusted flaggers" and promote "independent counter-narratives".[51] While the promotion of counter-narratives may be attractive in the face of "extremist" or "terrorist" content, pressure for such approaches runs the risk of transforming platforms into carriers of propaganda well beyond established areas of legitimate concern.[52]

Commission nationale de l'informatique et des libertés (CNIL) (case C-507/17), Global Network Initiative submission, p. 6.

[43] Compare Twitter Transparency Report: Removal Requests (January–June 2017) with Twitter Transparency Report: Government Terms of Service Reports (January–June 2017). See also Facebook, Government requests: Frequently Asked Questions (FAQs).

[44] Submissions by ARTICLE 19, p. 2 and Global Network Initiative, p. 5.

[45] European Union, Internet Referral Unit, Year One Report, sect. 4.11; submissions by European Digital Rights (EDRi), p. 1 and Access Now, pp. 2–3.

[46] Australia submission.

[47] Southeast Asian Press Alliance, p. 1.

[48] Digital Rights Foundation submission.

[49] 7amleh – The Arab Center for the Advancement of Social Media submission.

[50] Association for Progressive Communications, p. 14 and 7amleh.

[51] "Trusted flaggers … refers to the status given to certain organisations which allows them to report illegal content through a special reporting system or channel, which is not available to normal users." European Commission, Code of Conduct on countering illegal hate speech online: First results on implementation (December 2016).

[52] The same companies created the Global Internet Forum to Counter Terrorism, an effort to develop industry-wide technological tools to remove terrorist content on their platforms. Google, "Update on the Global Internet Forum to Counter Terrorism", 4 December 2017.

B. Company moderation of content

Company compliance with national law

22. Each company is committed in principle to comply with the local law where it does business. As Facebook puts it: "If, after careful legal review, we determine that the content is illegal under local law, then we make it unavailable in the relevant country or territory."[53] Tencent, the owner of the mobile chat and social media app WeChat, goes considerably further, requiring anyone using the platform within China and Chinese citizens using the platform "anywhere in the world" to comply with content restrictions that mirror Chinese law or policy.[54] Several companies also collaborate with one another and regulatory bodies to remove images of child sexual abuse.[55]

23. The commitment to legal compliance can be complicated when relevant State law is vague, subject to varying interpretations or inconsistent with human rights law. For instance, laws against "extremism" which leave the key term undefined provide discretion to government authorities to pressure companies to remove content on questionable grounds.[56] Similarly, companies are often under pressure to comply with State laws that criminalize content that is said to be, for instance, blasphemous, critical of the State, defamatory of public officials or false. As explained below, the Guiding Principles provide tools to minimize the impact of such laws on individual users. The Global Network Initiative, a multi-stakeholder initiative that helps ICT companies navigate human rights challenges, has developed additional guidance on how to employ these tools.[57] One tool of minimization is transparency: many companies report annually on the number of government requests they receive and execute per State.[58] However, companies do not consistently disclose sufficient information about how they respond to government requests, nor do they regularly report government requests made under terms of service.[59]

Company moderation standards

24. Internet companies require their users to abide by terms of service and "community standards" that govern expression on their platforms.[60] Company terms of service, which users are required to accept in exchange for use of the platform, identify jurisdictions for dispute resolution and reserve to themselves discretion over content and account actions.[61] Platform content policies are a subset of these terms, articulating constraints on what users may express and how they may express it. Most companies do not explicitly base content

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[53] Facebook, Government requests FAQs. See also Google legal removal requests, Twitter rules and policies, Reddit content policy.

[54] Tencent, Terms of Service: Introduction, Tencent, Agreement on Software License and Service of Tencent Wenxin.

[55] United Nations Educational, Scientific and Cultural Organization, *Fostering Freedom Online: The Role of Internet Intermediaries* (Paris, 2014), pp. 56–57.

[56] See Maria Kravchenko, "Inappropriate enforcement of anti-extremist legislation in Russia in 2016", SOVA Center for Information and Analysis, 21 April 2017; Danielle Citron, "Extremist speech, compelled conformity, and censorship creep", *Notre Dame Law Review*, vol. 93, No. 3 (2018), pp. 1035–1071.

[57] Global Network Initiative, Principles on Freedom of Expression and Privacy, sect. 2. Social media companies participating in the Initiative include Facebook, Google, Microsoft/LinkedIn and Yahoo/Oath.

[58] See paragraph 39 below. In addition, Automattic, Google, Microsoft/Bing and Twitter are among the companies that regularly, although not necessarily comprehensively, post government takedown and intellectual property requests to the Lumen database.

[59] Ranking Digital Rights, 2017 Corporate Accountability Index, p. 28.

[60] Jamila Venturini and others, *Terms of Service and Human Rights: An Analysis of Online Platform Contracts* (Rio de Janeiro, Revan, 2016).

[61] Baidu user agreement ("[We] remove and delete any content in this service based on Baidu's own discretion for any reason."); Tencent terms of service ("We reserve the right to block or remove Your Content for any reason, including as is in our opinion appropriate or as required by applicable laws and regulations."); Twitter terms of service ("We may suspend or terminate your account or cease providing you with all or part of the Services at any time for any or no reason.").

standards on any particular body of law that might govern expression, such as national law or international human rights law. The Chinese search giant Baidu, however, prohibits content that is "opposed to the basic principles established by the Constitution" of the People's Republic of China.[62]

25. The development of content moderation policies typically involves legal counsel, public policy and product managers, and senior executives. Companies may establish "trust and safety" teams to address spam, fraud and abuse, and counter-terrorism teams may address terrorist content.[63] Some have developed mechanisms for soliciting input from outside groups on specialized aspects of content policies.[64] The exponential increase in user-generated content has triggered the development of detailed and constantly evolving rules. These rules vary according to a range of factors, from company size, revenue and business model to the "platform's brand and reputation, its tolerance for risk, and the type of user engagement it wishes to attract".[65]

Areas of concern around content standards

26. *Vague rules*. Company prohibitions of threatening or promoting terrorism,[66] supporting or praising leaders of dangerous organizations[67] and content that promotes terrorist acts or incites violence[68] are, like counter-terrorism legislation, excessively vague.[69] Company policies on hate, harassment and abuse also do not clearly indicate what constitutes an offence. Twitter's prohibition of "behavior that incites fear about a protected group" and Facebook's distinction between "direct attacks" on protected characteristics and merely "distasteful or offensive content" are subjective and unstable bases for content moderation.[70]

27. *Hate, harassment, abuse*. The vagueness of hate speech and harassment policies has triggered complaints of inconsistent policy enforcement that penalizes minorities while reinforcing the status of dominant or powerful groups. Users and civil society report violence and abuse against women, including physical threats, misogynist comments, the posting of non-consensual or fake intimate images and doxing;[71] threats of harm against the politically disenfranchised,[72] minority races and castes[73] and ethnic groups suffering from violent persecution;[74] and abuse directed at refugees, migrants and asylum seekers.[75] At the same time, platforms have reportedly suppressed lesbian, gay, bisexual, transgender and queer activism,[76] advocacy against repressive Governments,[77] reporting on ethnic cleansing[78] and critiques of racist phenomena and power structures.[79]

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[62] Baidu terms of service, sect. 3.1.

[63] Monika Bickert, "Hard questions: how we counter terrorism", 15 June 2017.

[64] See, for example, Twitter Trust and Safety Council and YouTube Trusted Flagger Program.

[65] Sarah Roberts, *Content Moderation* (University of California at Los Angeles, 2017). See also ARTICLE 19 submission, p. 2.

[66] Twitter rules and policies (violent extremist groups).

[67] Facebook community standards (dangerous organizations).

[68] YouTube policies (violent or graphic content policies).

[69] See A/HRC/31/65, para. 39.

[70] Facebook community standards (hate speech); Twitter rules and policies (hateful conduct policy).

[71] Amnesty International, *Toxic Twitter: A Toxic Place for Women*; Association for Progressive Communications submission, p. 2.

[72] Submissions by 7amleh and Association for Progressive Communications, p. 15.

[73] Ijeoma Oluo, "Facebook's complicity in the silencing of black women", Medium, 2 August 2017; submissions by Center for Communications Governance, p. 5 and Association for Progressive Communications, pp. 11–12.

[74] Statement by the Special Rapporteur on the situation of human rights in Myanmar, Yanghee Lee, to the thirty-seventh session of the Human Rights Council, 12 March 2018.

[75] Association for Progressive Communications submission, p. 12.

[76] Electronic Frontier Foundation submission, p. 5.

[77] Ibid.; submissions by Association for Progressive Communications and 7amleh.

[78] Betsy Woodruff, "Facebook silences Rohingya reports of ethnic cleansing", The Daily Beast, 18 September 2017; ARTICLE 19 submission, p. 9.

28. The scale and complexity of addressing hateful expression presents long-term challenges and may lead companies to restrict such expression even if it is not clearly linked to adverse outcomes (as hateful advocacy is connected to incitement in article 20 of the International Covenant on Civil and Political Rights). Companies should articulate the bases for such restrictions, however, and demonstrate the necessity and proportionality of any content actions (such as removals or account suspensions). Meaningful and consistent transparency about enforcement of hate speech policies, through substantial reporting of specific cases, may also provide a level of insight that even the most detailed explanations cannot offer.[80]

29. *Context*. Companies emphasize the importance of context when assessing the applicability of general restrictions.[81] Nonetheless, attention to context has not prevented removals of depictions of nudity with historical, cultural or educational value;[82] historical and documentary accounts of conflict;[83] evidence of war crimes;[84] counter speech against hate groups;[85] or efforts to challenge or reclaim racist, homophobic or xenophobic language.[86] Meaningful examination of context may be thwarted by time and resource constraints on human moderators, overdependence on automation or insufficient understanding of linguistic and cultural nuance.[87] Companies have urged users to supplement controversial content with contextual details, but the feasibility and effectiveness of this guidance are unclear.[88]

30. *Real-name requirements*. In order to deal with online abuse, some companies have "authentic identity" requirements;[89] others approach identity questions more flexibly.[90] The effectiveness of real-name requirements as safeguards against online abuse is questionable.[91] Indeed, strict insistence on real names has unmasked bloggers and activists using pseudonyms to protect themselves, exposing them to grave physical danger.[92] It has also blocked the accounts of lesbian, gay, bisexual, transgender and queer users and activists, drag performers and users with non-English or unconventional names.[93] Since online anonymity is often necessary for the physical safety of vulnerable users, human rights principles default to the protection of anonymity, subject only to limitations that would protect their identities.[94] Narrowly crafted impersonation rules that limit the ability of users to portray another person in a confusing or deceptive manner may be a more proportionate means of protecting the identity, rights and reputations of other users.[95]

31. *Disinformation*. Disinformation and propaganda challenge access to information and the overall public trust in media and government institutions. The companies face

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[79] Julia Angwin and Hannes Grassegger, "Facebook's secret censorship rules protect white men from hate speech but not black children", ProPublica, 28 June 2017.

[80] See paras. 52 and 62 below.

[81] Twitter, "Our approach to policy development and enforcement philosophy"; YouTube policies (the importance of context); Richard Allan, "Hard questions: who should decide what is hate speech in an online global community?", Facebook Newsroom, 27 June 2017.

[82] Submissions by OBSERVACOM, p. 11 and ARTICLE 19, p. 6.

[83] WITNESS submission, pp. 6–7.

[84] Ibid.

[85] Electronic Frontier Foundation submission, p. 5.

[86] Association for Progressive Communications submission, p. 14.

[87] See Allan, "Hard questions".

[88] YouTube policies (the importance of context); Facebook community standards (hate speech).

[89] Facebook community standards (using your authentic identity). Note that Facebook now permits exceptions to its real-name policy on a case-by-case basis, but this has been criticized as insufficient: Access Now submission, p. 12. Baidu even requires the use of personally identifying information: Baidu user agreement.

[90] Twitter Help Center, "Help with username registration"; Instagram, "Getting started on Instagram".

[91] J. Nathan Matias, "The real name fallacy", Coral Project, 3 January 2017.

[92] Access Now submission, p. 11.

[93] Dia Kayyali, "Facebook's name policy strikes again, this time at Native Americans", Electronic Frontier Foundation, 13 February 2015.

[94] See A/HRC/29/32, para. 9.

[95] Twitter rules and policies (impersonation policy).

increasing pressure to address disinformation spread through links to bogus third-party news articles or websites, fake accounts, deceptive advertisements and the manipulation of search rankings.[96] However, because blunt forms of action, such as website blocking or specific removals, risk serious interference with freedom of expression, companies should carefully craft any policies dealing with disinformation.[97] Companies have adopted a variety of responses, including arrangements with third-party fact checkers, heightened enforcement of advertisement policies, enhanced monitoring of suspicious accounts, changes in content curation and search ranking algorithms, and user trainings on identifying false information.[98] Some measures, particularly those that enhance restrictions on news content, may threaten independent and alternative news sources or satirical content.[99] Government authorities have taken positions that may reflect outsized expectations about technology's power to solve such problems alone.[100]

Company moderation processes and tools

32. *Automated flagging, removal and pre-publication filtering*. The massive scale of user-generated content has led the largest companies to develop automated moderation tools. Automation has been employed primarily to flag content for human review, and sometimes to remove it. Automated tools scanning music and video for copyright infringement at the point of upload have raised concerns of overblocking, and calls to expand upload filtering to terrorist-related and other areas of content threaten to establish comprehensive and disproportionate regimes of pre-publication censorship.[101]

33. Automation may provide value for companies assessing huge volumes of user-generated content, with tools ranging from keyword filters and spam detection to hash-matching algorithms and natural language processing.[102] Hash matching is widely used to identify child sexual abuse images, but its application to "extremist" content — which typically requires assessment of context — is difficult to accomplish without clear rules regarding "extremism" or human evaluation.[103] The same is true with natural language processing.[104]

34. *User and trusted flagging*. User flags give individuals the ability to log complaints of inappropriate content with content moderators. Flags typically do not enable nuanced discussions about appropriate boundaries (e.g., why content may be offensive but, on balance, better left up).[105] They have also been "gamed" to heighten pressure on platforms to remove content supportive of sexual minorities and Muslims.[106] Many companies have developed specialized rosters of "trusted" flaggers, typically experts, high-impact users and, reportedly, sometimes government flaggers.[107] There is little or no public information

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[96] Ibid., Allen Babajanian and Christine Wendel, "#FakeNews: innocuous or intolerable?", Wilton Park report 1542, April 2017.

[97] Joint Declaration 2017.

[98] Submissions by Association for Progressive Communications, pp. 4–6 and ARTICLE 19, p. 4.

[99] Association for Progressive Communications submission, p. 5.

[100] See communication No. OL ITA 1/2018. Cf. European Commission, *A Multi-Dimensional Approach to Disinformation: Final Report of the Independent High-level Group on Fake News and Disinformation* (Luxembourg, 2018).

[101] The United Kingdom of Great Britain and Northern Ireland reportedly developed a tool to automatically detect and remove terrorist content at the point of upload. Home Office, "New technology revealed to help fight terrorist content online", 13 February 2018.

[102] Center for Democracy and Technology, *Mixed Messages? The Limits of Automated Media Content Analysis* (November 2017), p. 9.

[103] Open Technology Institute submission, p. 2.

[104] Center for Democracy and Technology, *Mixed Messages?*, p. 4.

[105] On user flags, see generally Kate Crawford and Tarleton Gillespie, "What is a flag for? Social media reporting tools and the vocabulary of complaint", *New Media and Society*, vol. 18, No. 3 (March 2016), pp. 410–428.

[106] Ibid., p. 421.

[107] YouTube Help, YouTube Trusted Flagger Program, YouTube Help, "Get involved with YouTube contributors".

explaining the selection of specialized flaggers, their interpretations of legal or community standards or their influence over company decisions.

35. *Human evaluation.* Automation often will be supplemented by human review, with the biggest social media companies developing large teams of content moderators to review flagged content.[108] Flagged content may be routed to content moderators, which will typically be authorized to make a decision — often within minutes — about the appropriateness of the content and to remove or permit it. In situations where the appropriateness of particular content is difficult to determine, moderators may escalate its review to content teams at company headquarters. In turn, company officials — typically public policy or "trust and safety" teams with the engagement of general counsel — will make decisions on removals. Company disclosure about removal discussions, in aggregate or specific cases, is limited.[109]

36. *Account or content action.* The existence of inappropriate content may trigger a range of company actions. Companies may limit content removal by jurisdiction, a range of jurisdictions, or across an entire platform or set of platforms. They may apply age limitations, warnings or demonetization.[110] Violations may lead to temporary account suspensions, while repeat offences may lead to account deactivation. In very few cases outside of copyright enforcement do the companies provide "counter-notice" procedures that permit users posting content to challenge removals.

37. *Notification.* A common complaint is that users who post reported content, or persons complaining of abuse, may not receive any notification of removal or other action.[111] Even when companies issue notifications, these typically indicate merely the action taken and a generic ground for action. At least one company has attempted to provide more context in its notifications, but it is unclear whether additional detail in stock notifications constitutes sufficient explanation in all cases.[112] Transparency and notifications go hand in hand: robust operational-level transparency that improves user awareness of the platform's approaches to content removals alleviates the pressure on notifications in individual cases, while weaker overall transparency increases the likelihood that users will be unable to understand individual removals in the absence of notifications tailored to specific cases.

38. *Appeals and remedies.* Platforms permit appeals of a range of actions, from profile or page removals to removals of specific posts, photos or videos.[113] Even with appeal, however, the remedies available to users appear limited or untimely to the point of non-existence and, in any event, opaque to most users and even civil society experts. It may be, for instance, that reinstatement of content would be an insufficient response if removal resulted in specific harm — such as reputational, physical, moral or financial — to the person posting. Similarly, account suspensions or content removals during public protest or debate could have significant impact on political rights and yet lack any company remedy.

Transparency

39. Companies have developed transparency reports that publish aggregated data on government requests for content removal and user data. Such reporting demonstrates the kinds of pressures the companies face. Transparency reporting identifies, country by

[108] See Sarah Roberts, "Commercial content moderation: digital laborers' dirty work", *Media Studies Publications*, paper 12 (2016).

[109] Cf. Wikipedia: BOLD, revert, discuss cycle. Reddit moderators are encouraged to offer "helpful rule explanations, tips and links to new and confused users" (Reddit Moddiquette).

[110] YouTube policies (nudity and sexual content policies); YouTube Help, "Creator influence on YouTube".

[111] Submissions by ARTICLE 19, p. 7 and Association for Progressive Communications, p. 16.

[112] See https://twitter.com/TwitterSafety/status/971882517698510848/.

[113] Electronic Frontier Foundation and Visualizing Impact, "How to appeal", onlinecensorship.org. Facebook and Instagram allow only the appeal of account suspensions. Cf. Github submission, p. 6.

country, the number of legal removal requests,[114] the number of requests where some action was taken or content restricted[115] and, increasingly, descriptions and examples of selected legal bases.[116]

40. However, as the leading review of Internet transparency concludes, companies disclose "the least amount of information about how *private* rules and mechanisms for self- and co-regulation are formulated and carried out".[117] In particular, disclosure concerning actions taken pursuant to private removal requests under terms of service is "incredibly low".[118] Content standards are drafted in broad terms, leaving room for platform discretion that companies do not sufficiently illuminate. Media and public scrutiny have led companies to supplement general policies with explanatory blog posts[119] and limited hypothetical examples,[120] but these fall short of illuminating nuances in how internal rules are developed and applied.[121] While terms of service are generally available in local languages, transparency reports, company blogs and related content are not, providing even less clarity to non-English-speaking users. Accordingly, users, public authorities and civil society often express dissatisfaction with the unpredictability of terms of service actions.[122] The lack of sufficient engagement, coupled with growing public criticism, has forced companies into a constant state of rule evaluation, revision and defence.

IV. Human rights principles for company content moderation

41. The founder of Facebook recently expressed his hope for a process in which the company "could more accurately reflect the values of the community in different places".[123] That process, and the relevant standards, can be found in human rights law. Private norms, which vary according to each company's business model and vague assertions of community interests, have created unstable, unpredictable and unsafe environments for users and intensified government scrutiny. National laws are inappropriate for companies that seek common norms for their geographically and culturally diverse user base. But human rights standards, if implemented transparently and consistently with meaningful user and civil society input, provide a framework for holding both States and companies accountable to users across national borders.

42. A human rights framework enables forceful normative responses against undue State restrictions — provided companies play by similar rules. The Guiding Principles and their accompanying body of "soft law" provide guidance on how companies should prevent or mitigate government demands for excessive content removals. But they also establish principles of due diligence, transparency, accountability and remediation that limit platform interference with human rights through product and policy development. Companies committed to implementing human rights standards throughout their operations — and not merely when it aligns with their interests — will stand on firmer ground when they seek to

[114] Twitter Transparency Report: Removal Requests (January–June 2017); Google Transparency Report: Government Requests to Remove Content; 2016 Reddit Inc., Transparency Report. Facebook does not provide the total number of requests received per country.

[115] See, for example, Facebook Transparency Report (France) (January–June 2017); Google Transparency Report: Government Requests to Remove Content (India); Twitter Transparency Report (Turkey).

[116] Ibid.

[117] Ranking Digital Rights submission, p. 4. Original italics.

[118] Ibid., p. 10.

[119] See Elliot Schrage, "Introducing hard questions", Facebook Newsroom, 15 June 2017; Twitter Safety, "Enforcing new rules to reduce hateful conduct and abusive behavior", 18 December 2017.

[120] See, for example, YouTube policies (violent or graphic content policies).

[121] Angwin and Grasseger, "Facebook's secret censorship rules".

[122] Submissions by Ranking Digital Rights, p. 10; OBSERVACOM p. 10; Association for Progressive Communications, p. 17; International Federation of Library Associations and Institutions, pp. 4–5; Access Now, p. 17; and EDRi, p. 5.

[123] Kara Swisher and Kurt Wagner, "Here's the transcript of Recode's interview with Facebook CEO Mark Zuckerberg about the Cambridge Analytica controversy and more", Recode, 22 March 2018.

hold States accountable to the same standards. Furthermore, when companies align their terms of service more closely with human rights law, States will find it harder to exploit them to censor content.

43. Human rights principles also enable companies to create an inclusive environment that accommodates the varied needs and interests of their users while establishing predictable and consistent baseline standards of behaviour. Amidst growing debate about whether companies exercise a combination of intermediary and editorial functions, human rights law expresses a promise to users that they can rely on fundamental norms to protect their expression over and above what national law might curtail.[124] Yet human rights law is not so inflexible or dogmatic that it requires companies to permit expression that would undermine the rights of others or the ability of States to protect legitimate national security or public order interests. Across a range of ills that may have more pronounced impact in digital space than they might offline — such as misogynist or homophobic harassment designed to silence women and sexual minorities, or incitement to violence of all sorts — human rights law would not deprive companies of tools. To the contrary, it would offer a globally recognized framework for designing those tools and a common vocabulary for explaining their nature, purpose and application to users and States.

A. Substantive standards for content moderation

44. The digital age enables rapid dissemination and enormous reach, but it also lacks textures of human context. Per the Guiding Principles, companies may take into account the size, structure and distinctive functions of the platforms they provide in assessing the necessity and proportionality of content restrictions.

45. *Human rights by default*. Terms of service should move away from a discretionary approach rooted in generic and self-serving "community" needs. Companies should instead adopt high-level policy commitments to maintain platforms for users to develop opinions, express themselves freely and access information of all kinds in a manner consistent with human rights law.[125] These commitments should govern their approach to content moderation and to complex problems such as computational propaganda[126] and the collection and handling of user data. Companies should incorporate directly into their terms of service and "community standards" relevant principles of human rights law that ensure content-related actions will be guided by the same standards of legality, necessity and legitimacy that bind State regulation of expression.[127]

46. "*Legality*". Company rules routinely lack the clarity and specificity that would enable users to predict with reasonable certainty what content places them on the wrong side of the line. This is particularly evident in the context of "extremism" and hate speech, areas of restriction easily susceptible to excessive removals in the absence of rigorous human evaluation of context. Further complicating public understanding of context-specific rules is the emerging general exception for "newsworthiness".[128] While the recognition of public interest is welcome, companies should also explain what factors are assessed in determining the public interest and what factors other than public interest inform calculations of newsworthiness. Companies should supplement their efforts to explain their rules in more detail with aggregate data illustrating trends in rule enforcement, and examples of actual cases or extensive, detailed hypotheticals that illustrate the nuances of interpretation and application of specific rules.

47. *Necessity and proportionality*. Companies should not only describe contentious and context-specific rules in more detail. They should also disclose data and examples that

[124] Global Partners Digital submission, p. 3; Guiding Principles, principle 11.

[125] Guiding Principles, principle 16.

[126] See Samuel Wooley and Philip Howard, *Computational Propaganda Worldwide: Executive Summary* (Computational Propaganda Research Project working paper No. 2017.11 (Oxford, 2017).

[127] Global Partners Digital submission, pp. 10–13.

[128] See Joel Kaplan, "Input from community and partners on our community standards", Facebook Newsroom, 21 October 2016; Twitter rules and policies.

provide insight into the factors they assess in determining a violation, its severity and the action taken in response. In the context of hate speech, explaining how specific cases are resolved may help users better understand how companies approach difficult distinctions between offensive content and incitement to hatred, or how considerations such as the intent of the speaker or the likelihood of violence are assessed in online contexts. Granular data on actions taken will also establish a basis to evaluate the extent to which companies are narrowly tailoring restrictions. The circumstances under which they apply less intrusive restrictions (such as warnings, age restrictions or demonetization) should be explained.

48. *Non-discrimination.* Meaningful guarantees of non-discrimination require companies to transcend formalistic approaches that treat all protected characteristics as equally vulnerable to abuse, harassment and other forms of censorship.[129] Indeed, such approaches would appear inconsistent with their own emphasis that context matters. Instead, when companies develop or modify policies or products, they should actively seek and take into account the concerns of communities historically at risk of censorship and discrimination.

B. Processes for company moderation and related activities

Responses to government requests

49. As company transparency reports show, Governments pressure them to remove content, suspend accounts and identify and disclose account information. Where required by local law, it may appear that companies have little choice but to comply. But companies may develop tools that prevent or mitigate the human rights risks caused by national laws or demands inconsistent with international standards.

50. *Prevention and mitigation.* Companies often claim to take human rights seriously. But it is not enough for companies to undertake such commitments internally and provide ad hoc assurances to the public when controversies arise. Companies should also, at the highest levels of leadership, adopt and then publicly disclose specific policies that "direct all business units, including local subsidiaries, to resolve any legal ambiguity in favour of respect for freedom of expression, privacy, and other human rights". Policies and procedures that interpret and implement government demands to narrow and "ensure the least restriction on content" should flow from these commitments.[130] Companies should ensure that requests are in writing, cite specific and valid legal bases for restrictions and are issued by a valid government authority in an appropriate format.[131]

51. When faced with problematic requests, companies should seek clarification or modification; solicit the assistance of civil society, peer companies, relevant government authorities, international and regional bodies and other stakeholders; and explore all legal options for challenge.[132] When companies receive requests from States under their terms of service or through other extralegal means, they should route these requests through legal compliance processes and assess the validity of such requests under relevant local laws and human rights standards.

52. *Transparency.* In the face of censorship and associated human rights risks, users can only make informed decisions about whether and how to engage on social media if interactions between companies and States are meaningfully transparent. Best practices on how to provide such transparency should be developed. Company reporting about State requests should be supplemented with granular data concerning the types of requests received (e.g., defamation, hate speech, terrorism-related content) and actions taken (e.g., partial or full removal, country-specific or global removal, account suspension, removal granted under terms of service). Companies should also provide specific examples as often

[129] See, for example, International Convention on the Elimination of All Forms of Racial Discrimination, arts. 1 (4) and 2 (2).

[130] See A/HRC/35/22, paras. 66–67.

[131] Submissions by Global Network Initiative, pp. 3–4 and GitHub, pp. 3–5.

[132] See A/HRC/35/22, para. 68.

as possible.[133] Transparency reporting should extend to government demands under company terms of service[134] and must also account for public-private initiatives to restrict content, such as the European Union Code of Conduct on countering illegal hate speech online, governmental initiatives such as Internet referral units and bilateral understandings such as those reported between YouTube and Pakistan and Facebook and Israel. Companies should preserve records of requests made under these initiatives and communications between the company and the requester and explore arrangements to submit copies of such requests to a third-party repository.

Rule-making and product development

53. *Due diligence*. Although several companies commit to human rights due diligence in assessing their response to State restrictions, it is unclear whether they implement similar safeguards to prevent or mitigate risks to freedom of expression posed by the development and enforcement of their own policies.[135] Companies should develop clear and specific criteria for identifying activities that trigger such assessments. In addition to revisions of content moderation policies and processes, assessments should be conducted on the curation of user feeds and other forms of content delivery, the introduction of new features or services and modifications to existing ones, the development of automation technologies and market-entry decisions such as arrangements to provide country-specific versions of the platform.[136] Past reporting also specifies the issues these assessments should examine and the internal processes and training required to integrate assessments and their findings into relevant operations. Additionally, these assessments should be ongoing and adaptive to changes in circumstances or operating context.[137] Multi-stakeholder initiatives such as Global Network Initiative provide an avenue for companies to develop and refine assessments and other due diligence processes.

54. *Public input and engagement*. Participants in consultations consistently raised concerns that companies failed to engage adequately with users and civil society, particularly in the global South. Input from affected rights holders (or their representatives) and relevant local or subject matter experts, and internal decision-making processes that meaningfully incorporate the feedback received, are integral components of due diligence.[138] Consultations — especially in broad forms such as calls for public comment — enable the companies to consider the human rights impact of their activities from diverse perspectives, while also encouraging them to pay close attention to how seemingly benign or ostensibly "community-friendly" rules may have significant, "hyper-local" impacts on communities.[139] For example, engagement with a geographically diverse range of indigenous groups may help companies develop better indicators for taking into account cultural and artistic context when assessing content featuring nudity.

55. *Rule-making transparency*. Companies too often appear to introduce products and rule modifications without conducting human rights due diligence or evaluating the impact in real cases. They should at least seek comment on their impact assessments from interested users and experts, in settings that guarantee the confidentiality of such assessments if necessary. They should also clearly communicate to the public the rules and processes that produced them.

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[133] See, for example, Twitter Transparency Report: Removal Requests (January–June 2017).

[134] Twitter has begun to publish data on "non-legal requests submitted by known government representatives about content that may violate the Twitter Rules" prohibiting abusive behaviour, promotion of terrorism and intellectual property infringement. Ibid. See also Microsoft, Content Removal Requests Report (January–June 2017).

[135] Ranking Digital Rights submission, p. 12; Guiding Principles, principle 17.

[136] See A/HRC/35/22, para. 53.

[137] Ibid., paras. 54–58.

[138] See Guiding Principles, principle 18 and A/HRC/35/22, para. 57.

[139] Chinmayi Arun, "Rebalancing regulation of speech: hyper-local content on global web-based platforms", Berkman Klein Center for Internet and Society Medium Collection, Harvard University, 2018; *Pretoria News*, "Protest at Google, Facebook 'bullying' of bare-breasted maidens", 14 December 2017.

Rule enforcement

56. *Automation and human evaluation*. Automated content moderation, a function of the massive scale and scope of user-generated content, poses distinct risks of content actions that are inconsistent with human rights law. Company responsibilities to prevent and mitigate human rights impacts should take into account the significant limitations of automation, such as difficulties with addressing context, widespread variation of language cues and meaning and linguistic and cultural particularities. Automation derived from understandings developed within the home country of the company risks serious discrimination across global user bases. At a minimum, technology developed to deal with considerations of scale should be rigorously audited and developed with broad user and civil society input.

57. The responsibility to foster accurate and context-sensitive content moderation practices that respect freedom of expression also requires companies to strengthen and ensure professionalization of their human evaluation of flagged content. This strengthening should involve protections for human moderators consistent with human rights norms applicable to labour rights and a serious commitment to involve cultural, linguistic and other forms of expertise in every market where they operate. Company leadership and policy teams should also diversify to enable the application of local or subject-matter expertise to content issues.

58. *Notice and appeal*. Users and civil society experts commonly express concern about the limited information available to those subject to content removal or account suspension or deactivation, or those reporting abuse such as misogynistic harassment and doxing. The lack of information creates an environment of secretive norms, inconsistent with the standards of clarity, specificity and predictability. This interferes with the individual's ability to challenge content actions or follow up on content-related complaints; in practice, however, the lack of robust appeal mechanisms for content removals favours users who flag over those who post. Some may argue that it will be time-consuming and costly to allow appeals on every content action. But companies could work with one another and civil society to explore scalable solutions such as company-specific or industry-wide ombudsman programmes. Among the best ideas for such programmes is an independent "social media council", modelled on the press councils that enable industry-wide complaint mechanisms and the promotion of remedies for violations.[140] This mechanism could hear complaints from individual users that meet certain criteria and gather public feedback on recurrent content moderation problems such as overcensorship related to a particular subject area. States should be supportive of scalable appeal mechanisms that operate consistently with human rights standards.

59. *Remedy*. The Guiding Principles highlight the responsibility to remedy "adverse impacts" (principle 22). However, few if any of the companies provide for remediation. Companies should institute robust remediation programmes, which may range from reinstatement and acknowledgment to settlements related to reputational or other harms. There has been some convergence among several companies in their content rules, giving rise to the possibility of inter-company cooperation to provide remedies through a social media council, other ombudsman programmes or third-party adjudication. If the failure to remediate persists, legislative and judicial intervention may be required.

60. *User autonomy*. Companies have developed tools enabling users to shape their own online environments. This includes muting and blocking of other users or specific kinds of content. Similarly, platforms often permit users to create closed or private groups, moderated by users themselves. While content rules in closed groups should be consistent with baseline human rights standards, platforms should encourage such affinity-based groups given their value in protecting opinion, expanding space for vulnerable communities and allowing the testing of controversial or unpopular ideas. Real-name requirements

[140] See ARTICLE 19, *Self-regulation and 'Hate Speech' on Social Media Platforms* (London, 2018), pp. 20–22.

should be disfavoured, given their privacy and security implications for vulnerable individuals.[141]

61. Mounting concerns about the verifiability, relevance and usefulness of information online raise complex questions about how companies should respect the right to access information. At a minimum, companies should disclose details concerning their approaches to curation. If companies are ranking content on social media feeds based on interactions between users, they should explain the data collected about such interactions and how this informs the ranking criteria. Companies should provide all users with accessible and meaningful opportunities to opt out of platform-driven curation.[142]

Decisional transparency

62. Notwithstanding advances in aggregate transparency of government removal requests, terms of service actions are largely unreported. Companies do not publish data on the volume and type of private requests they receive under these terms, let alone rates of compliance. Companies should develop transparency initiatives that explain the impact of automation, human moderation and user or trusted flagging on terms of service actions. While a few companies are beginning to provide some information about these actions, the industry should be moving to provide more detail about specific and representative cases and significant developments in the interpretation and enforcement of their policies.

63. The companies are implementing "platform law", taking actions on content issues without significant disclosure about those actions. Ideally, companies should develop a kind of case law that would enable users, civil society and States to understand how the companies interpret and implement their standards. While such a "case law" system would not involve the kind of reporting the public expects from courts and administrative bodies, a detailed repository of cases and examples would clarify the rules much as case reporting does.[143] A social media council empowered to evaluate complaints across the ICT sector could be a credible and independent mechanism to develop such transparency.

V. Recommendations

64. **Opaque forces are shaping the ability of individuals worldwide to exercise their freedom of expression. This moment calls for radical transparency, meaningful accountability and a commitment to remedy in order to protect the ability of individuals to use online platforms as forums for free expression, access to information and engagement in public life. The present report has identified a range of steps, include the following.**

Recommendations for States

65. **States should repeal any law that criminalizes or unduly restricts expression, online or offline.**

66. **Smart regulation, not heavy-handed viewpoint-based regulation, should be the norm, focused on ensuring company transparency and remediation to enable the public to make choices about how and whether to engage in online forums. States should only seek to restrict content pursuant to an order by an independent and impartial judicial authority, and in accordance with due process and standards of legality, necessity and legitimacy. States should refrain from imposing disproportionate sanctions, whether heavy fines or imprisonment, on Internet intermediaries, given their significant chilling effect on freedom of expression.**

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[141] See para. 30 above.

[142] Facebook, for example, permits users to view stories in their News Feed in reverse chronological order, but warns that it will "eventually" return to its default curation settings. Facebook Help Centre, "What's the difference between top stories and most recent stories on News Feed?"

[143] See, for example, Madeleine Varner and others, "What does Facebook consider hate speech?", ProPublica, 28 December 2017.

67. States and intergovernmental organizations should refrain from establishing laws or arrangements that would require the "proactive" monitoring or filtering of content, which is both inconsistent with the right to privacy and likely to amount to pre-publication censorship.

68. States should refrain from adopting models of regulation where government agencies, rather than judicial authorities, become the arbiters of lawful expression. They should avoid delegating responsibility to companies as adjudicators of content, which empowers corporate judgment over human rights values to the detriment of users.

69. States should publish detailed transparency reports on all content-related requests issued to intermediaries and involve genuine public input in all regulatory considerations.

Recommendations for ICT companies

70. Companies should recognize that the authoritative global standard for ensuring freedom of expression on their platforms is human rights law, not the varying laws of States or their own private interests, and they should re-evaluate their content standards accordingly. Human rights law gives companies the tools to articulate and develop policies and processes that respect democratic norms and counter authoritarian demands. This approach begins with rules rooted in rights, continues with rigorous human rights impact assessments for product and policy development, and moves through operations with ongoing assessment, reassessment and meaningful public and civil society consultation. The Guiding Principles on Business and Human Rights, along with industry-specific guidelines developed by civil society, intergovernmental bodies, the Global Network Initiative and others, provide baseline approaches that all Internet companies should adopt.

71. The companies must embark on radically different approaches to transparency at all stages of their operations, from rule-making to implementation and development of "case law" framing the interpretation of private rules. Transparency requires greater engagement with digital rights organizations and other relevant sectors of civil society and avoiding secretive arrangements with States on content standards and implementation.

72. Given their impact on the public sphere, companies must open themselves up to public accountability. Effective and rights-respecting press councils worldwide provide a model for imposing minimum levels of consistency, transparency and accountability to commercial content moderation. Third-party non-governmental approaches, if rooted in human rights standards, could provide mechanisms for appeal and remedy without imposing prohibitively high costs that deter smaller entities or new market entrants. All segments of the ICT sector that moderate content or act as gatekeepers should make the development of industry-wide accountability mechanisms (such as a social media council) a top priority.

United Nations A/HRC/38/36

General Assembly

Distr.: General
10 April 2018

Original: English

Human Rights Council
Thirty-eighth session
18 June–6 July 2018
Agenda item 3
Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Note by the Secretariat

The Secretariat has the honour to transmit to the Human Rights Council the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, prepared pursuant to Council resolution 33/9. In the report, the Special Rapporteur addresses the relationship between the right to health and specific forms of deprivation of liberty and confinement in penal and medical regimes. Detention and confinement remain the policy tool preferred by States to promote public safety, "morals" and public health, doing more harm than good to public health and the realization of the right to physical and mental health. The Special Rapporteur calls for the full implementation of the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) and for the development of supportive community-based services as alternatives to detention and confinement in various cases.

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Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Contents

		Page
I.	Introduction	3
II.	The right to health in the context of confinement and deprivation of liberty	5
	A. Intrinsic links, systemic omissions	5
	B. Right-to-health framework	6
III.	Relationship between mental health and forced confinement and deprivation of liberty	10
IV.	Children deprived of liberty	11
	A. Overview	12
	B. Penal institutions	12
V.	Women, the right to health, and confinement	14
	A. Addressing the gendered pathways of incarceration	15
	B. Conditions of incarceration	16
	C. Women with disabilities	17
VI.	From confinement to community: ending public-health detention	17
	A. Criminalization as a determinant of the right to health for people living with tuberculosis	18
	B. Community-based care and tuberculosis	19
VII.	Conclusions and recommendations	19

I. Introduction

1. In previous reports and country missions, the Special Rapporteur has attempted to shed light on how exclusion has negatively affected the right to health of those deprived of basic liberties and freedoms. In the present report, he uses a right-to-health framework to problematize the global approach to deprivation of liberty and confinement, pointing towards transformative directions for reform.

2. Given the breadth and scale of these issues, a comprehensive assessment is not possible within the space constraints of the present report. This is an initial contribution, focused on some practices where the right to health is a key element in meaningful assessment and guidance.

3. The report is a synthesis of insights acquired during country missions, literature reviews and multiple assessments of cases brought to the attention of the Special Rapporteur through the communications mechanism of the special procedures. The report was significantly informed and enriched through extensive consultations with a wide range of stakeholders, including people who have been deprived of their liberty, civil society representatives, members of the prison abolition movement, public-health experts, the World Health Organization (WHO) and academic experts. The Special Rapporteur is grateful for their generous commitment of time, energy and meaningful contributions.

4. Deprivation of liberty is a legally grounded term, and involves severe restriction of motion within a space that is narrower than that of other forms of interference with liberty of movement. It should be based on a judicial sentence, and is imposed without free consent. It is not prohibited per se, but such detention must be lawful and not arbitrary. Deprivation of liberty takes many forms, including police custody, remand detention, imprisonment after conviction, house arrest and administrative detention, as well as both involuntary hospitalization and institutional custody of children resulting from legal proceedings.[1]

5. Confinement is a term widely used in health and social welfare settings to indicate the restriction of an individual within a limited area, following medical or social-welfare advice. It may occur with or without the consent of the person and may include some generally accepted health-grounded practices, such as those applied in the context of the recovery period after a woman has given birth.[2]

6. While some forms of confinement, including retention in hospitals and in psychiatric and other medical facilities, may constitute de facto deprivation of liberty,[3] virtually all forms of confinement without informed consent represent a violation of the right to health.

7. Around the world, more than 10 million adults are imprisoned in penal settings.[4] These statistics fail to capture the global scale of persons restricted in other settings. For example, it is estimated that at least one million children are being held in other settings, that half a million adults are in compulsory drug detention and that thousands of women are being held in hospitals for non-payment of bills. An inestimable number of adults and children are confined in medical and social institutions, including persons with tuberculosis who are forcibly isolated for long durations, sometimes in prison-like settings. While the places of confinement differ, the shared experience of exclusion exposes a common narrative of deep disadvantage, discrimination, violence and hopelessness.

8. Restrictions on the liberty of movement have emerged in the past two centuries as the default tool of social control to promote public safety, "morals" and public health. This has included the detention, on the grounds of behaviour socially labelled as "immoral", of,

[1] See Human Rights Committee, general comment No. 35 (2014) on liberty and security of person, paras. 3, 5–6 and 10–14; see also E/CN.4/2005/6, para. 54.

[2] See Committee on the Elimination of Discrimination against Women, general recommendation No. 24 (1999) on women and health, paras. 2, 8, 22, 26 and 31.

[3] See A/HRC/30/37, para. 9.

[4] Roy Walmsley, World Prison Population List, 11th ed. (World Prison Brief and Institute for Criminal Policy Research).

among others, lesbian, gay, bisexual, transgender and intersex persons, rebellious young persons, drug users and women exercising their right to make choices concerning pregnancy prevention and termination. Confinement has become an institutional response to complex social problems, particularly affecting groups and communities left behind by public and socioeconomic policies. Some argue that prison systems and institutions are powerful instruments aimed at silencing the opposition or the "other", through either criminal sanctions or medical diagnosis and isolation.

9. The latter part of the twentieth century was marked by a rapid increase in rates of confinement within punitive legal and policy frameworks, including in relation to the drug trade, that laid the foundation for modern day, fast-track prison pipelines. Rapid deinstitutionalization in some countries, without corresponding investment in quality community-based services, occurred in parallel. People living in poverty and/or belonging to racial and ethnic minorities were caught in a widening punitive net with inadequate social, economic and legal protections.

10. The 2030 Agenda for Sustainable Development reflects the ambitious aspiration to end the vicious cycle of hopelessness, violence, exclusion and discrimination by addressing social inequalities and human rights so that no one, including persons confined or deprived of their liberty, is left behind.[5] There is strong evidence that any form of violence, including inside prisons and centres of confinement, poses a risk for the full realization of the right to health.[6] Many promising innovations are prioritizing investment in early childhood, healthy adolescence, competent parenting, good mental health and well-being, gender equality and the protection of women from violence, giving hope that the world can and will become less violent and that detention and confinement will decrease substantially.

11. For the first time, the field of mental health, supported by the Convention on the Rights of Persons with Disabilities other powerful political commitments,[7] is on the verge of freeing itself from a pattern of coercion and institutionalization in mental health settings.

12. Similarly, drug prohibition is increasingly acknowledged as a failed practice that has devastating consequences in terms of the right to health. A growing number of countries and municipalities are replacing punitive approaches to the use of drugs with modern policies based on public health and human rights principles, including decriminalization or legal regulation of drug markets and scaled-up investments in community-based social and health-care services, including harm reduction.[8] These promising trends give hope that the practice of mass incarceration of drug users may end.

13. New and stronger international political commitments to reduce incarceration where appropriate have been established.[9] A number of United Nations entities and human rights mechanisms have called for the immediate closure of all compulsory drug detention centres and/or movement towards the decriminalization of non-violent drug offences.[10] The global study on children deprived of liberty commissioned by the Secretary-General at the

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[5] For more on the 2030 Agenda in the context of the right to health, see A/71/304.

[6] See, for example, World Health Organization, *World Report on Violence and Health* (2002).

[7] See, for example, Human Rights Council resolution 36/13.

[8] United Nations Development Programme, *Reflections on Drug Policy and Its Impact on Human Development: Innovative Approaches* (2016).

[9] For example, the Doha Declaration on Integrating Crime Prevention and Criminal Justice into the Wider United Nations Agenda to Address Social and Economic Challenges and to Promote the Rule of Law at the National and International Levels, and Public Participation.

[10] See A/65/255; A/HRC/32/32; joint statement by United Nations entities on compulsory drug detention and rehabilitation centres, issued in March 2012, available from www.unodc.org/documents/southeastasiaandpacific//2012/03/drug-detention-centre/JC2310_Joint_Statement6March12FINAL_En.pdf; joint United Nations statement on ending discrimination in health-care settings, issued in July 2017, available from www.unaids.org/sites/default/files/media_asset/ending-discrimination-healthcare-settings_en.pdf; "Tackling the world drug problem: UN experts urge States to adopt human rights approach", press release, available from www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=19833&LangID=E.

invitation of the General Assembly holds much promise in terms of elevating the movement towards ending children's imprisonment.

14. On the other hand, there are many signs of increases in the use of confinement for minor offences and as the default response to problems relating to public safety, social order, immigration, political opposition or "morality". In some cases, punitive responses are applied disproportionately to address violence or radical extremism among young people. Growing numbers of women are being incarcerated, with a worrying number detained for choices regarding their reproductive health rights. The warehousing of refugees and migrants seeking safety and refuge remains a critical challenge.

15. Improving the conditions of the daily existence of the millions held in locked cells and wards and radically reducing the rates of such imprisonment remain of paramount importance. Equally important is the forging of efforts to fortify and transform communities to support reintegration, inclusive education, socioeconomic empowerment and well-being and, hence, the meaningful fulfilment of the right to the highest attainable standard of mental and physical health.

16. We are at a crucial point in terms of influencing how we conclude this decade and shape the next as regards ending the cultural dependence on confinement and incarceration.

II. The right to health in the context of confinement and deprivation of liberty

A. Intrinsic links, systemic omissions

17. Ensuring dignity by protecting the right to health has been an objective of prison reform legislation and advocacy since the earliest days of the modern prison. The current structures of confinement produce a vast geography of pain that transcends borders, resource settings and political systems. This is intimately linked to the right to health and well-being, not only of those deprived of liberty and confined, but also of communities, families, children and future generations. It is vital to consider the cyclical and transgenerational harm these systems produce.[11]

18. Securing the right to health is necessary for the enjoyment of a range of other rights. In contexts of confinement and deprivation of liberty, violations of the right to health interfere with fair trial guarantees, the prohibition of arbitrary detention and of torture and other forms of cruel, inhuman or degrading treatment, and the enjoyment of the right to life. Violations of the right to health emerge as both causes and consequences of confinement and deprivation of liberty.

19. The Special Rapporteur highlights five ways in which the links between the right to health and confinement and deprivation of liberty are evident:

(a) Failure to secure the right to health in early childhood through a comprehensive system of health care contributes to inequalities, poverty, discrimination and poor health in adulthood, feeding facilities of detention and confinement. The vast majority of people in closed settings come from marginalized and low-income communities;

(b) Punitive legal frameworks and public policies that make incarceration likelier hinder the realization of the right to health. Such frameworks and policies include laws criminalizing certain behaviours, identities or status (sex work, sexual orientation, gender identity, drug use, HIV status, non-adherence to tuberculosis treatment and exposure to infectious diseases) and health services needed only by women (i.e., abortion); the selective enforcement of loitering, vagabond and public disorder laws against those living in marginalized situations; and prohibitionist drug laws and policies that produce, inter alia, violent illicit drug markets and that lead to incarceration, driving people who use drugs away from community health care while providing little for health care inside prisons.

[11] Bruce Western and Becky Pettit, "Incarceration & social inequality", *Daedalus* (summer, 2010).

Broad and sweeping public-health frameworks established by law limit the toolbox available to policymakers for addressing health challenges, making detention and confinement the dominant and most restrictive means for addressing health concerns that are, according to evidence, better responded to in supportive community environments;

(c) The dominance of detention and confinement as a response to issues of public safety and public health has led to a monopolization of resources that should be redistributed to support the progressive development of robust health-care systems, safe and supportive schools, programmes to support healthy relationships, access to development opportunities and an environment free from violence;

(d) Safeguarding the right to health once a person is incarcerated is a challenging task. Prison itself becomes a determinant of poor health as a result of poor conditions of detention, the provision of health care under surveillance and/or a lack of access to health care, the enormous psychosocial pain and hopelessness linked to being deprived of liberty, and untreated pre-existing health conditions attributable to the conditions of living in poverty.[12] Mortality rates are high; in many cases, suicides and premature deaths in custody, almost all preventable, conclude harrowing tales of lives cut short;

(e) Detention and confinement among young, low-income families who have lost breadwinners and primary care providers to incarceration have a devastating impact on the social fabric of communities. Upon release, people commonly receive no health-care support when reintegrating into society. Furthermore, without robust health-care systems in the community, deinstitutionalization may lead to tragedy.[13] Criminal records, post-release surveillance and commitment orders follow individuals into their political, social and working lives, lowering resilience, creating barriers to opportunity and integration and ultimately undermining the right to health.

20. In sum, the enjoyment of the right to health in the context of confinement and deprivation of liberty is conspicuous by its absence.

B. Right-to-health framework

21. Human rights standards aimed at safeguarding persons deprived of liberty, or in confinement, against violations of their rights exist. However, the specificity of the normative scope and a lack of political will restrict the scope of responses to this highly complex social phenomena. A structural assessment, from a right-to-health perspective, of the "climate" of prison, detention and confinement, that is, how people experience life and survive once inside, how power is structured and organized and the structural factors that enable practices and institutions to persist, would help to broaden such responses.[14]

Obligations of the State

22. Under article 12 of the International Covenant on Economic, Social and Cultural Rights, States have the obligation to respect, protect and fulfil the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The Committee on Economic, Social and Cultural Rights has stated that, under the same article, States are obligated to refrain from denying or limiting equal access for all persons, including prisoners or detainees, to preventive, curative and palliative health services.[15] Other

[12] Dora M. Dumont and others, "Public health and the epidemic of incarceration", *Annual Review of Public Health*, vol. 33 (April 2012), and Ernest Drucker, *A Plague of Prisons: The Epidemiology of Mass Incarceration in America* (New York, New Press, 2013).

[13] See, for example, the joint urgent appeal, dated 28 November 2016 addressed to the Permanent Mission of South Africa to the United Nations Office and other international organizations in Geneva. Available from https://spcommreports.ohchr.org/TMResultsBase/DownLoadPublicCommunicationFile?gId=22868.

[14] Tomas Max Martin, Andrew M. Jefferson and Mahuya Bandyopadhyay, "Sensing prison climates: governance, survival and transition", *Focaal*, No. 68 (2014).

[15] See general comment No. 14 (2000) on the right to the highest attainable standard of health, para. 34.

international human rights treaties also contain provisions to protect the right to health of specific groups, including persons in situations of deprivation of liberty and confinement.

23. The Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) include provisions on the responsibility of States regarding health care for persons detained in prisons (rules 24–35). For example, States have the obligation to ensure that medical services in prisons guarantee continuity of treatment and care, including for HIV infection, tuberculosis and other infectious diseases, and drug dependence. Also set out in the Rules is the obligation to transfer prisoners requiring specialized treatment to specialized institutions or civil hospitals, and to ensure that clinical decisions are taken solely by responsible health-care professionals and not overruled or ignored by non-medical prison staff.

24. Bearing in mind the goal of the progressive realization of the right to health, measures are needed to ensure its realization in closed settings, including a plan to end forced confinement in hospitals and long-term care institutions. Such a plan must be supported by strategies to strengthen community-based alternatives.[16]

Informed consent[17]

25. The right to informed consent is a fundamental element of the right to physical and mental health. Informed consent involves a voluntary and sufficiently informed decision, and serves to promote a person's autonomy, self-determination, bodily integrity and well-being. It encompasses the right to consent to, refuse or choose an alternative medical treatment.[18]

26. While the right to consent to and refuse treatment involves careful consideration in the context of life-saving procedures, it must otherwise be respected, protected and fulfilled, notably in cases of isolation and confinement, where support and encouragement must be provided so that treatment is completed voluntarily. However, the right to consent to treatment continues to be ambiguously applied among those deprived of liberty, who remain at a high risk of being subjected to coercive, involuntary or mandatory testing and treatment, including compulsory drug testing, research trials and, among hunger strikers, force-feeding; in other cases, organs have been removed from executed prisoners without prior consent. These types of practices are harmful and some have implications on the reporting of symptoms for testing and treatment of stigmatized infections, such as HIV infection and tuberculosis.

Equality and non-discrimination

27. Entrenched inequalities and discrimination characterize the experience of deprivation of liberty and confinement, from the discriminatory apprehension of persons to the discriminatory and inequitable arrangement of services once a person is deprived of liberty or confined.

28. Health and prison officials often perpetuate discrimination through the denial of health care, including opioid substitution therapy, clean needles and syringes, antiretroviral therapy, and sexual health supplies or contraceptives. The status of being incarcerated can elicit prejudicial action by prison and health officials. Those seeking health care in prisons, detention centres and settings of confinement, particularly those with serious health issues, are often denied access as a form of informal punishment; access has also been denied where they are wrongly deemed to lack legal capacity on the basis of a perceived or actual impairment or other reasons. Barriers to ensuring non-discriminatory access to health care, including health-care facilities that are independently regulated outside the penal system, must be addressed immediately. The failures of staff training in this regard demonstrate the need for alternative and assertive approaches.

[16] A/HRC/35/21.

[17] For more on the issue of informed consent, see A/64/272, paras. 9, 28, 34 and 79–84.

[18] Ibid., para. 10.

International cooperation and assistance

29. International human rights treaties recognize the obligation of international cooperation, which includes cooperation regarding the right to health. International cooperation linked to the realization of a wide range of rights is also recognized in Sustainable Development Goal 17. Higher-income States have a particular responsibility to provide assistance in the area of the right to health, including as it relates to adequate access to health care in prisons and other settings of detention and confinement. International assistance should not support prison and health systems that are discriminatory or where violence, torture and other human rights violations occur. This is particularly so in the cases of drug detention centres, large psychiatric institutions and other long-term segregated care institutions.[19]

30. Through international cooperation, support for community-based health interventions should be scaled up to effectively safeguard individuals from discriminatory, arbitrary, excessive or inappropriate deprivation of liberty and confinement. It is worrying to see the continued imbalance between multilateral and bilateral assistance provided for the administration of justice and that provided for rights-based community investment. More work is needed to better understand the full scope of projects that continue to fund closed settings and impede community-based investment in health and social welfare.

Underlying determinants of health

31. Various factors affect the physical environment of persons who are deprived of liberty or confined. Adverse conditions can include poor sanitation and poor access to nutritional food, fresh air and potable drinking water. Some facilities were constructed on land contaminated with carcinogens.[20]

32. In these settings, including but not restricted to prisons, violence is common and takes many forms, including physical and sexual abuse by staff and peers, the use of physical and chemical restraints, forced medical treatment and solitary confinement. Furthermore, sexual violence against women has shown in multiple cases to be systematic and widespread. The most silent forms of adverse conditions of detention and confinement, including boredom and powerlessness, can often prove to be the most severe, notably affecting mental health while giving rise to feelings of hopelessness and despair and suicide attempts.

33. Overall, centres of detention or confinement are not therapeutic environments. In a previous report, the Special Rapporteur identified the underlying determinants of the right to mental health, including the creation and maintenance of non-violent, respectful and healthy relationships in families, communities and society at large.[21] In detention or confinement, where the person is surrounded by staff tasked with restricting freedom, it is difficult to establish these type of relationships, which hinder the full and effective realization of the right to mental health.[22] Even with noble efforts to establish a strong culture of respect and care, violence and humiliation usually prevails, adversely affecting the development of healthy relationships.

Health care

34. As elsewhere, for the right to health to be enjoyed in detention centres, health-care facilities, goods and services must be available, accessible, acceptable and of good quality.

35. Even with the most comprehensive health system in place, structural barriers may impede the full and effective realization of the right to health. Centres of detention and

[19] A/65/255, A/HRC/35/21.

[20] Judah Schept, "Sunk capital, sinking prisons, stinking landfills: landscape, ideology and the carceral state in Central Appalachia", in Michelle Brown and Eamonn Carrabine (eds.), *Routledge Handbook of Visual Criminology* (New York, Routledge, 2017).

[21] A/HRC/35/21.

[22] Peter Stastny, "Involuntary psychiatric interventions: a breach of the Hippocratic oath?" *Ethical Human Sciences and Services*, vol. 2, No. 1 (spring, 2000).

confinement often concentrate people from the most vulnerable situations, including those who are medically vulnerable. The centres are often characterized by inhumane physical and psychosocial environments and unequal structures of power frequently rooted within racist and violent pasts. The unpopularity and powerlessness of those deprived of liberty and confined leave them with no voice and few defenders to advocate for their dignity. These factors shape an ecology of deprivation that significantly compromises the ethical and effective organization and delivery of health care.

36. The availability of health-care services in detention and confinement centres is often compromised by managerial procurement decisions, particularly when those services are segregated from mainstream public-health infrastructure. Decisions to not make available certain health-care services are often taken by penal-oriented administrators instead of independent public-health actors, and security and punishment eclipse concerns for health. In many low-income settings, prison health systems lack the resources necessary to ensure the most basic provisions of health care.

37. In such settings, the accessibility of available health-care services is often dependent on negotiations with staff tasked with control and containment. Many people are denied access to appropriate medical services because of punitive or negligent actions of security staff. This has led to egregious violations of human rights, including preventable deaths.

38. In terms of acceptability, health-care services must: respect human rights and medical ethics; be culturally appropriate, sensitive to gender and life-cycle requirements and designed to respect confidentiality; and improve the health status of those concerned. Services in settings of confinement and deprivation of liberty must be culturally appropriate, as well as acceptable to adolescents, women, older persons, persons with disabilities, indigenous persons, minorities and lesbian, gay, bisexual, transgender and intersex persons.

39. As regards quality, evidence-based health-care protocols and practices must be used to support people who are deprived of liberty or confined, the majority of whom, because of their structural situation of disadvantage, will require significant provision of quality physical and mental health care. However, the delivery of such services faces systemic obstacles. The climate of deprivation and control adversely affects relationships, undermining the quality of health care. The absence of resources, particularly in low-income settings, further exacerbates this environment. The inappropriate use or overprescription of psychotropic medications, common in prisons as a means of behaviour control, and the use of solitary confinement, isolation and forced medical treatment are issues of quality of care and do not promote and protect the right to health. In higher-resource prison settings, cognitive-behavioural and other behaviour modification programmes raise serious questions of quality. Such programmes perpetuate individualistic approaches to offending as "abnormal", masking the political and social contexts that shape the lives and choices of those who have been detained or confined.

Participation

40. The effective realization of the right to health requires the participation of everyone, including those deprived of liberty or confined, or most at risk, in decision-making at the legal, policy and community levels, in particular in the area of health care. At the population level, enabling everyone to participate meaningfully in decisions about their right to health requires inclusive engagement, such as with those currently and formerly deprived of liberty and confined, their families, police, prison administrators, medical professionals, social workers, penal reformers and abolitionists and the wider community.

41. Health-care services in closed settings must empower users as rights holders to exercise autonomy and participate meaningfully and actively in all matters concerning them and to make their own choices about their health, with appropriate support where needed.

42. The inclusion of the voices of those directly affected must be encouraged, although this remains complicated owing to deeply unequal penal and medical power dynamics. Prisoner-led trade unions, voting rights movements and documentation projects, and movements of users and survivors of mental health systems, as well as the inclusive engagement of academia and the non-governmental sector, are powerful means for promoting meaningful participation.

Accountability

43. Accountability for the realization of the right to health requires three elements: monitoring; review, including by judicial, quasi-judicial and political or administrative bodies and social accountability mechanisms; and remedies and redress. Accountability is vital if the right to health inside prisons and other confinement settings is to be realized in practice.

44. Despite the commendable efforts of several monitoring mechanisms, human rights violations in prison and other centres of detention and confinement continue to be committed with impunity in a widespread and systematic manner. Individuals held in such centres often have limited or no access to independent accountability mechanisms, frequently because no monitoring body exists. Mechanisms charged with monitoring centres of deprivation of liberty rarely consider structural barriers, such as the disproportional detention of people in situations of vulnerability, including medical vulnerability, the existence of unequal power structures, often rooted in racist and violent pasts, and the little to no access to channels through which to voice demands, including health-care related demands.

45. The Special Rapporteur encourages national human rights institutions and national preventive mechanisms to give attention to those structural challenges. A right-to-health approach can be a useful tool in their monitoring and promotion functions. Persons formerly or currently deprived of liberty or confined, their families and civil society should be engaged in the development and implementation of accountability arrangements.

III. Relationship between mental health and forced confinement and deprivation of liberty

46. Actual and de facto deprivation of liberty has adverse effects on mental health, which may amount to violations of the right to health. Solitary confinement and protracted or indefinite detainment, including decades of detention in prisons or other closed settings, negatively influence mental health and well-being. The rates of poor mental health in prisons worldwide far exceed the rates in the general population. Being deprived of liberty itself is an emotionally fraught experience, carrying with it potential exposure to inhumane and crowded conditions, violence and abuse, separation from family and community, the loss of autonomy and control over daily living and an environment of fear and humiliation, and the absence of constructive, stimulating activities. Suicide rates in prisons are at least three times higher than those in the general community.[23]

47. While there has been a surge in research on mental health in prisons, it has been mostly limited to academic psychiatry and focused on disease prevalence and on improving services during confinement. There remains a dearth of research on how the constraints of a closed environment itself, particularly a punitive one, presents significant obstacles to the delivery of quality health care to those who are most in need.

48. Apart from recognizing that many people who are currently detained or confined should not be, there is an emerging consensus that prisons are not conducive to effective mental health treatment and that they are not the place for people identified as having a mental condition. This view, however, has led to forced confinement in mental health facilities, sometimes for indefinite periods, without meaningful safeguards to protect the right to health, to build on recovery or to guard against arbitrariness. For example, persons with intellectual and psychosocial disabilities who are in conflict with the law and who are deemed incapable of forming a rational judgment about their conduct ("insanity" defence) end up being held in custody in medical or security facilities instead.

49. The Convention on the Rights of Persons with Disabilities includes relevant provisions in this connection (arts. 12 and 14). The Committee on the Rights of Persons with Disabilities has established that the provisions represent an absolute prohibition on

[23] Seena Fazel and Jacques Baillargeon, "The health of prisoners", *The Lancet*, vol. 377 (2010).

involuntary confinement, including involuntary commitment of persons with intellectual and psychosocial disabilities to mental health facilities, strictly on the basis of actual or perceived impairment, as such confinement carries with it the denial of the person's legal capacity to decide about care, treatment, and admission to a hospital or institution.[24]

50. In accordance with the above-mentioned Convention, the recognition of legal capacity, including of persons with intellectual and psychosocial disabilities, applies to all aspects of life, including for the purposes of equal standing in courts and tribunals. In this regard, the Committee has recognized that if persons with disabilities, including intellectual and psychosocial disabilities, in conflict with law are deprived of liberty through a lawful and non-arbitrary process, they must be provided with reasonable accommodation that preserves their dignity, including in prison.[25]

51. The Special Rapporteur acknowledges these provisions. He echoes his previous call for a paradigm shift in the field of mental health, which abandons outdated measures resulting in the forced confinement of persons with intellectual and psychosocial disabilities in psychiatric institutions. He calls on States, international organizations and other stakeholders to undertake concerted efforts to radically reduce the use of institutionalization in mental health-care settings, with a view to eliminating such measures and institutions. He also calls on States to provide reasonable accommodation inside prisons for persons with all forms of disability lawfully and non-arbitrarily deprived of liberty, in a way that preserves their dignity.

52. Foundational to the way forward is the need for serious discussion about the role that perceptions of mental conditions play in propagating structures of confinement, underpinned by a false dichotomy that an individual coming into conflict with the law is either "mad" or "bad". People in conflict with the law, including those who may have a mental health condition, cannot be reduced to this binary categorization. The Special Rapporteur welcomes the growing debate around the subjective labelling of individuals and the inherent risks of diversion into coercive mental health settings. A fundamental part of this debate must include how the "insanity" defence and other criminal justice tools, such as mental health courts and security measures, may perpetuate systemic human rights failures in prisons and mental health settings. Many initiatives to provide mental health services in the community, without coercion or confinement, have shown promise. Empowerment is a basic precondition for the recovery of many persons who struggle with critical psychosocial challenges. Empowerment and recovery cannot happen in closed settings. Healthy, therapeutic relationships, based on mutual trust, should be fostered between users and providers of mental health-care services.

IV. Children deprived of liberty

53. The scale and magnitude of children's suffering in detention and confinement call for a global commitment to the abolition of child prisons and large care institutions alongside scaled-up investment in community-based services.

54. The Standard Minimum Rules for the Treatment of Prisoners, the first such rules adopted in the United Nations context, deliberately did not prescribe conditions and protection for child detainees, because they contained the principle that young persons should not be sentenced to imprisonment, which was repeated in the Nelson Mandela Rules. For over 30 years, United Nations rules in respect of juvenile justice have required that children be placed in institutions only as a measure of last resort and for the minimum duration possible.[26] States members of the United Nations long ago committed to depenalization and non-custodial measures for both children and adults.[27] Diverting

[24] Guidelines on the right to liberty and security of persons with disabilities.

[25] Ibid.

[26] United Nations Standard Minimum Rules for the Administration of Juvenile Justice ("the Beijing Rules"), rule 19.1; see also the United Nations Rules for the Protection of Juveniles Deprived of their Liberty ("the Havana Rules"), rule 1.

[27] United Nations Standard Minimum Rules for Non-custodial Measures ("the Tokyo Rules").

children from contact with the criminal justice system is now considered part of a strategy for ending violence against children within criminal justice settings.[28] The global study on children deprived of liberty commissioned by the Secretary-General is to include recommendations for the implementation of that strategy.[29]

55. Many of the damaging characteristics of prisons that we know to critically impede the enjoyment of the right to health by detained children, especially in terms of their psychological and emotional development, are also evident in large institutions nominally aimed at securing their welfare, including infant homes and education, health and welfare facilities for children with disabilities. Additionally, penal institutions are used to administratively detain children for political "offences", national security and immigration control. As such, all forms of detention severely compromise children's enjoyment of the rights to health, to healthy development and to maximum survival and development, in contravention of the International Covenant on Economic, Social and Cultural Rights (art. 12) and the Convention on the Rights of the Child (arts. 6 and 24).

A. Overview

56. There are no global statistics on the total number of children deprived of their liberty. Around one million children were estimated to be in detention in criminal justice systems at the turn of the millennium; in some countries, the majority were awaiting trial. Many were detained for non-criminal behaviour associated with poverty and discrimination, themselves breaches of children's rights. The independent expert for the United Nations study on violence against children found violence to be widespread in penal institutions.[30]

57. The likelihood of being detained as a child is linked to the social determinants of health.[31] Poverty, social exclusion, militarized school systems, gender, ethnicity and disability are all factors associated with the loss of liberty in childhood. Children from economically and socially disadvantaged communities, including those from ethnic minorities and indigenous populations, as well as those in care systems, are disproportionately deprived of liberty. Children with disabilities are more likely to be held in institutions, and to suffer appalling violence, often in the guise of "treatment".[32] Scaled up investment in tackling these underlying determinants of health is not only an obligation for the progressive realization of the right to health, but a promising strategy to prevent incarceration over the long term.

58. The Special Rapporteur has witnessed children with disabilities growing up entirely within the forced confines of large institutions, eventually moving into social welfare institutions for adults. While designed with good intentions, such paternalistic models are not compliant with various provisions protecting children's rights, including their right to healthy development. This sad legacy of confinement begins at the start of life in infant homes, characterized by emotional neglect that is itself a form of institutional violence. The Special Rapporteur reiterates previous calls to fully eliminate institutional care of children under 5 years of age and replace it with a comprehensive family support system.[33] This single measure, if taken seriously, could prevent millions from being deprived of their liberty.

59. While the Convention on the Rights of the Child does not exclude the detention of children, the strongest of presumptions against it are established (art. 37 (b)). Children may be detained only as a measure of last resort. This standard is not to be used retrospectively to justify existing structures. Instead, it is an obligation to exhaust all other strategies at the macro level and all other interventions at the micro level.

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[28] See the United Nations Model Strategies and Practical Measures on the Elimination of Violence against Children in the Field of Crime Prevention and Criminal Justice, paras. 30–31.

[29] General Assembly resolution 69/157.

[30] See A/61/299, paras. 61–62.

[31] A/HRC/7/11 and Corr.1.

[32] Paulo Sérgio Pinheiro, *World Report on Violence against Children* (2006), pp. 185 and 188.

[33] See, for example, A/70/213.

B. Penal institutions

60. Penal institutions were designed principally for adults. At best, separate facilities are provided for children, but they are still modelled on adult prisons. Prison is one of several forms of immigration detention used around the world. The fundamental right of the child to care and protection can never be realized within penal institutions.[34]

61. Children have been confined in cells, wards, corridors, exercise yards and visiting areas for weeks, months or even years. Childhood is a uniquely precious time in a young person's development; in penal settings, fresh air, windows and opportunities to play, exercise and explore outside are strictly limited, if available at all. A lack of nutritious and wholesome food saps children's energy; squalid conditions spread infection and disease. For children in immigration detention, release from captivity prior to deportation equals the loss of places they call home and the people linked to those places. Escorted transfers from an institution to an aircraft robs children of any final opportunity to say goodbye.

62. The impact of penal institutions stretches far beyond the curtailment of children's physical freedom; their mental well-being and potential for psychological and cognitive growth are all deeply and negatively affected. Research evidence shows that immigration detention aggravates pre-existing trauma in children. For some it is the worst experience of their lives.[35]

63. Adolescence is a critical period of cognitive and emotional development, affecting the whole of adulthood. The Special Rapporteur remains deeply concerned about how punitive responses to youth violence affect adolescent health and development.[36] Criminalization and incarceration have increased, despite the evidence that public-health approaches deliver better results.[37] In reality, children held in penal institutions, including for acts of violence, are those whose early childhood needs and rights have not been fulfilled. International human rights law requires children to be treated in accordance with their age and best interests.[38] Ensuring the full and harmonious development of children in society, from infancy to adolescence, is a core strategy for preventing youth crime.[39]

64. Since the entry into force of the Convention on the Rights of the Child, neuroscience research has revealed that the brains of adolescents are still developing in many critical ways. This calls into serious question the rationale for punitive, closed environments and methods of control.[40] Corporal punishment, humiliation, coercion and the denial of supportive environments that can ensure healthy, non-violent relationships and physical comfort can never elicit positive, long-term change in a child's behaviour.[41]

65. Many children are detained due to their mother's incarceration, when it is considered in the child's best interests to remain with his or her mother. The Special Rapporteur is of the view that this is too limited as an assessment of best interests. States must weigh the

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[34] See the Convention on the Rights of the Child, arts. 3 (2) and 40.

[35] International Detention Coalition, *Captured Childhood: Introducing a New Model to Ensure the Rights and Liberty of Refugee, Asylum Seeker and Irregular Migrant Children Affected by Immigration Detention* (2012), p. 49.

[36] The Committee on the Rights of the Child expressed similar concerns; see its general comment No. 13 (2011) on the right of the child to freedom from all forms of violence, para. 15 (c).

[37] Arianna Silvestri and others, *Young People, Knives and Guns: A Comprehensive Review, Analysis and Critique of Gun and Knife Crime Strategies* (London, Centre for Crime and Justice Studies, 2009), pp. 61–67.

[38] Convention on the Rights of the Child, arts. 3 and 37; Convention on the Rights of Persons with Disabilities, art. 7 (2).

[39] See United Nations Guidelines for the Prevention of Juvenile Delinquency (the Riyadh Guidelines), paras. 1–6.

[40] Barry Goldson and Ursula Kilkelly, "International human rights standards and child imprisonment: potentialities and limitations", *The International Journal of Children's Rights*, vol. 21, No. 2 (2013).

[41] WHO and International Society for Prevention of Child Abuse and Neglect, *Preventing Child Maltreatment: A Guide to Taking Action and Generating Evidence* (2006); Global Initiative to End All Corporal Punishment of Children, "Corporal punishment of children: review of research on its impact and associations", working paper (2016).

societal interests in punishing women with incarceration, for what are most often non-violent offences, with the best interests of the child and the obligation set out in article 37 (b) of the Convention on the Rights of the Child. That obligation requires the implementation of all means possible to avoid the detention of the child, including alternative models and responses for mothers.

66. The solitary confinement of children and the degrading and humiliating conditions in detention have been described as mental violence.[42] Many other daily forms of "organized hurt"[43] are perpetrated though no less pernicious means. Children's creativity, communication, sleeping, waking, playing, learning, resting, socializing and relationships are compulsively controlled in detention and transgressions punished, while those administering the punishment enjoy impunity.

67. Daily deprivations are often complemented by behavioural interventions in order to "treat" and "reform". Such "treatment" approaches further entrench the idea of a troubled child "in need of repair", ignoring that changes are needed to address right-to-health determinants, such as inequalities, poverty, violence and discrimination, especially among groups in vulnerable situations. This, in turn, leads to children living in forced confinement and fuels their struggles. Such oversimplified strategies are not in conformity with the right to health.

68. Coping mechanisms employed by stressed and desperate children, which include assaults against themselves and others, are perceived by society and judicial and welfare systems as acts that are self-harming, anti-social and/or violent. The harm inflicted by institutions themselves too often goes unacknowledged.

69. There can be no hesitation in concluding that the act of detaining children is a form of violence. The Convention on the Rights of the Child prohibits the use of detention as a default strategy. Looking forward, a child rights-based strategy must strengthen even further the presumption against detention of children with a view to abolition.

V. Women, the right to health, and confinement

70. Women comprise a small minority (7 per cent) of the global prison population, but the number of incarcerated women is increasing and at a greater rate than that of incarcerated men.[44] The number of women and young girls held outside of criminal justice settings worldwide is unknown. Most are first-time offenders suspected of, or charged with, minor, non-violent offences, pose no risk to the public and should probably not be in prison at all.[45] Paradoxically, the meteoric rise of women in detention regimes over the past two decades has brought greater visibility and gender-focused reforms, but with limited improvements as regards the suffering of detained women and the increase in their numbers.[46]

71. The suffering experienced by women who are imprisoned or involuntarily confined and the related negative impact on the enjoyment of their right to health is understood to be significantly greater than that experienced by men. Power and authority in prisons and other places of detention and confinement, such as large psychiatric institutions, emerge from historical patriarchal, hyper-masculinist constructions of punishment and control.[47] The acceptability of such environments for the realization of the right to health and for the well-being of women is thus questionable.

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[42] See Committee on the Rights of the Child, general comment No. 13, para. 21.

[43] Hans von Hentig, *Punishment: Its Origin, Purpose and Psychology* (1937); Barry Goldson, "Child imprisonment: a case for abolition", *Youth Justice*, vol. 5, No. 2 (August 2005).

[44] Roy Walmsley, World Female Imprisonment List, 4th ed. (2017).

[45] United Nations Office on Drugs and Crime (UNODC), *Handbook on Women in Prison*, 2nd ed. (United Nations publication, Sales No. E.14.IV.3).

[46] Cassandra Shaylor, "Neither kind nor gentle: the perils of 'gender responsive justice'", in Phil Scraton and Jude McCulloch, eds., *The Violence of Incarceration* (Routledge, 2008).

[47] M. Bandypadhyay, "Competing masculinities in a prison", *Men and Masculinities*, vol. 9, No. 2 (2006).

72. The manner in which women are actually or de facto deprived of liberty arises from structural inequalities and discrimination, harmful gender stereotypes and deep disadvantage, which lead to failure to secure their rights to social and underlying determinants of health, to reproductive autonomy, to an environment free from gender-based violence, and to services and support in the community. Once women are inside, the gendered and challenging environment of detention and confinement compounds their immediate and long-term health risks, reproduces past violence and trauma, and undermines the full and effective realization of the right to health for themselves and their dependent children and families left on the outside.

A. Addressing the gendered pathways of incarceration

73. Studies in several countries have found that violence, sexual, physical and emotional abuse and economic dependence are linked to women's incarceration. Many women in prison are mothers and the primary, if not only, caregivers for their children or other family members. In many countries, prison sentences for women lead to the incarceration of their infants or young children. Children left behind have limited contact with their mothers, often struggling to cope, living in street situations, in institutions, in foster care or with relatives.[48]

74. In some countries, pregnant women who use drugs, including legally prescribed drugs, face civil or criminal detention for extended periods of time, sometimes for the length of the pregnancy. This can have a discriminatory impact on women with disabilities who take prescription drugs while pregnant.[49] In other countries, women are imprisoned for "moral crimes", such as adultery or extramarital relationships, or to protect them from gender-based violence ("honour crimes").[50]

75. Criminal laws and legal provisions that restrict access to sexual and reproductive health goods, services and information also contribute to women's imprisonment.[51] In some States, dispensing information on preventing interrupting pregnancy or materials deemed to conflict with notions of "morality" or "decency" is criminalized with punishments ranging from fines to imprisonment. Criminal laws have also been used to prosecute women for other conduct, including failure to follow a doctor's orders during pregnancy, failing to refrain from sexual intercourse and concealing a birth.[52] Where abortion is illegal, women may face imprisonment for seeking an abortion and emergency services for pregnancy-related complications, including those due to miscarriages. Fear of criminal punishment for "aiding or abetting" abortions can lead health-care providers to report people suffering from pregnancy complications to authorities.[53]

76. A substantial proportion of women in prison are incarcerated for non-violent, low-level drug offences: between 40 and 80 per cent in some countries in the Americas, Europe and Asia.[54] While men are more likely than women to be involved in the drug trade, a

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[48] United Nations Development Programme, *Addressing the Development Dimensions of Drug Policy* (2015), p. 26; Moira O'Neil, Nathaniel Kendall-Taylor and Susan Nall Bales, "Communicating about women and criminal justice in the United Kingdom", FrameWorks Research Brief (June, 2015), p. 3; Carolyne Willow, *Children Behind Bars: Why the Abuse of Child Imprisonment Must End* (Policy Press, 2015).

[49] Amnesty International, *Criminalizing Pregnancy: Policing Pregnant Women Who Use Drugs in the USA* (2017).

[50] A/68/340.

[51] A/66/254, A/68/340 and A/HRC/14/20.

[52] See A/66/254, paras. 18, 38 and 62.

[53] See, for example, CEDAW/C/SLV/CO/8-9, paras. 37–38.

[54] See A/68/340, paras. 23–24; Rebecca Schleifer and Luciana Pol, "International guidelines on human rights and drug control: a tool for securing women's rights in drug control policy", *Health and Human Rights Journal*, vol. 19, No. 1 (2017); Thailand Institute of Justice, *Women Prisoners and the Implementation of the Bangkok Rules in Thailand* (2014).

significantly higher proportion of women than men are imprisoned for drug-related offences.[55]

77. In many countries, the proportion of women held in pretrial detention is equal to or larger than that of convicted female prisoners.[56] This heightens vulnerability to sexual abuse and other forms of coercion that can be used to extract confessions[57] and is compounded by race, disability, foreign national status and other situations of social discrimination.

78. Keeping women out of the criminal justice system in the first place by, for example, repealing laws criminalizing access to, and information about, sexual and reproductive health-care services, consensual adult sex, "morality" and minor drug offences is critical to protecting the right to health.

B. Conditions of incarceration

79. Once incarcerated, women often face discrimination based on sex and/or disability and are subjected to treatment and conditions that mirror the violence and abuse the majority have experienced prior to their detention. In a number of countries, because of the limited accommodation available for women prisoners, women are subjected to security levels not justified by the risk assessment undertaken on admission.[58] The lack of available medical or mental health services may also result in women being placed in more secure facilities than otherwise indicated.[59] The situation is exacerbated for women with disabilities because of the scarcity of facilities to accommodate them, and even more so for women with psychosocial or intellectual disabilities, whose actual or perceived impairment is often used as the basis for higher levels of security.[60]

80. Like their male counterparts, women in prisons recurrently face overcrowding, violence and unsanitary conditions detrimental to their mental and physical health and conducive to the spread of disease. It is frequently the case that little or no attention is paid to women-specific health-care needs, such as those related to menstruation, pregnancy and childbirth, menopause and sexual and reproductive health.[61] The lack of gender-specific health care in prison, including the lack of specialized obstetric and reproductive health services, poor treatment by staff, medical neglect and denial of medicines, lack of privacy for medical exams and confidentiality, and discrimination regarding access to harm reduction services, may amount to ill-treatment or in some cases torture,[62] and amounts to a violation of the right to health.

81. International standards require "special accommodation for all necessary prenatal and postnatal care and treatment" in women's prisons,[63] and that "adequate and timely food" and a healthy environment be provided free of charge for, among others, pregnant women and breastfeeding mothers.[64] However, prenatal care is inadequate or non-existent in many prisons, even where widely available in the general population, and nutrition substandard.[65]

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[55] Joanne Csete and others, "Public health and international drug policy", *The Lancet*, vol. 387 (April 2016); A/68/340, para. 26; CEDAW/C/BRA/CO/7 and Corr.1, para. 32; A/54/38/Rev.1, part two, para. 312.

[56] UNODC, *Handbook on Women and Imprisonment*.

[57] Open Society Justice Initiative, *Presumption of Guilt: The Global Overuse of Pretrial Detention* (New York, Open Society Foundations, 2014); UNODC, *Handbook on Women and Imprisonment*.

[58] UNODC, *Handbook on Women and Imprisonment*.

[59] See, for example, Anti-Discrimination Commission Queensland, *Women in Prison* (2006). Available from https://www.adcq.qld.gov.au/__data/assets/pdf_file/0018/5148/WIP_report.pdf.

[60] UNODC, *Handbook on Women and Imprisonment*.

[61] A/68/340. See also Human Rights Watch, *Going to the Toilet When You Want: Sanitation as a Human Right* (2017).

[62] See A/HRC/31/57, para. 26.

[63] The Nelson Mandela Rules, rule 28.

[64] United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules), rule 48.

[65] A/68/340.

Mistreatment of women during childbirth has been reported in prisons and immigration detention centres. Punishment by closed confinement and disciplinary segregation should not be applied to pregnant women, women with infants and breastfeeding mothers.[66]

C. Women with disabilities

82. Women with disabilities, especially psycho-social disabilities, are disproportionately represented in prisons, both as compared to the general population and vis-à-vis male prisoners.[67] The closure of psychiatric institutions and the lack of adequate housing, mental health and social services in communities have contributed to the increase in the population of women with psychosocial disabilities in prison.[68] The medicalization of women's behaviour and the construction of women in conflict with the law as "mad", "irrational" and "in need of repair" has contributed to the labelling of women in prison as having mental health conditions where men would not have been, and in turn, to the over-prescription of psychotropic medications for women suffering from normal levels of distress associated with detention.

83. Many prisons fail to provide reasonable accommodation to people with disabilities, which has significant consequences on their enjoyment of the right to health and, in some cases, may violate prohibitions against torture and ill-treatment.[69] The misclassification of women with mental disabilities as higher risk also impede their chances of early release, exacerbating existing mental health conditions.

84. The story of how women end up actually or de facto deprived of liberty, and the high levels of violence and suffering they experience once inside detention facilities, is closely linked to failures to respect, protect and fulfil their right to health. Gender-responsive reforms have failed to effectively address these challenges, which disproportionally affect women in vulnerable, disadvantaged and marginalized situations.

VI. From confinement to community: ending public-health detention

85. Confinement has long constituted a public-health strategy to stem the spread of infectious diseases and viruses, including leprosy, HIV and tuberculosis. Various legal frameworks, including national mental health laws, legitimize forced confinement on broad and subjective grounds, including medical necessity and dangerousness. Routinely, and in some cases increasingly, confinement is the policy instrument of choice for addressing complex social and public-health issues. Guided by worst-case scenarios, policies and practices regularly have a significant impact on groups in marginalized situations, entrapping them in criminal or public-health detention regimes on the basis of a health condition. This is despite mounting evidence that health outcomes for these groups, and for the communities in which they live, are better with health care and support in community settings. The place of public-health detention in our rapidly changing global world is a topical and important debate. In the light of the upcoming high-level meeting on the fight

[66] The Bangkok Rules, rule 22.

[67] United States of America, Department of Justice, "Disabilities among prison and jail inmates, 2011-12" (2015); Janet I. Warren and others, "Personality disorders and violence among female prison inmates", *Journal of the American Academy of Psychiatry and the Law*, vol. 30 (2002); Emma Plugge, Nicola Douglas and Ray Fitzpatrick, *The Health of Women in Prison: Study Findings* (University of Oxford, 2006).

[68] Jennifer M. Kilty, "'It's like they don't want you to get better': Psy control of women in the carceral context", *Feminism & Psychology*, vol. 22, No. 2 (April 2012).

[69] European Court of Human Rights, *Price v. the United Kingdom*, application No. 33394/96, judgment of 10 July 2001, and *D.G. v. Poland*, application No. 45705/07, judgment of 12 February 2013; United States Court of Appeals, Sixth Circuit, *Stoudemire v. Michigan Department of Corrections et al.*, case No. 14-1742, decision of 22 May 2015.

against tuberculosis, to be held pursuant to General Assembly resolution 71/159, in the present chapter the Special Rapporteur will focus on the illustrative case of tuberculosis.

86. Few populations experience more risk factors for tuberculosis than people deprived of liberty, owing to factors ranging from poor nutrition and unhygienic conditions to poor medical care. Prevalence rates in prisons are 3 to 1,000 times higher than those among the general population; prison populations account for 25 per cent of the tuberculosis burden in some countries.[70]

87. Rights violations contributing to the spread of tuberculosis result not only from the conditions of detention, but also from punitive responses to this and other infectious diseases, including criminalization, isolation, coercion and forced hospitalization. Too often, today's approaches to tuberculosis are as archaic as the disease itself and lack a modern, community-based approach to secure the right to health and better address the disease. Realization of the right to health requires a full commitment to developing responses to tuberculosis in the community, moving towards the full elimination of the use of punitive measures, including confinement, as a response.

A. Criminalization as a determinant of the right to health for people living with tuberculosis

88. Incarceration and detention approaches not only impede the realization of the rights to health, to informed consent, to privacy and to freedom from treatment, from inhuman and degrading treatment and of movement, but can also worsen social inequalities and lead to a paradoxical increase in tuberculosis incidence.[71]

89. In some countries, national laws permit mandatory hospitalization and forced treatment for persons with tuberculosis, in contravention of the right to informed consent, further creating fear and stigmatization of both the disease and people suffering from it. This drives people with tuberculosis symptoms away from the needed health care. Certain laws explicitly provide that examinations, hospitalization and observation may be carried out, isolation may be imposed and medical treatment may be provided without consent, in some cases without a court order. Some countries have tuberculosis-specific laws that include stigmatizing language, for example suggesting that people with the disease maliciously evade treatment, and authorize non-consensual hospitalization. Such legal frameworks reflect outdated approaches to health care, including approaches in which the amount of funding a health facility receives is determined by the number of occupied hospital beds.

90. People who are deprived of liberty disproportionately come from groups in disadvantaged situations who often have inadequate access to health-care services. Placing them in closed settings increases the risk that they will not have access to health care and can lead to the spread of tuberculosis where prison conditions, including overcrowding, poorly ventilated spaces, inadequate prevention, medical care and treatment, stress, malnutrition and denial of harm reduction services, elevate the risk of infection and transmission,[72] as does the high HIV rate in prisons.[73] People in detention often do not have adequate access to counselling and information about medicine and the side effects of treatment. Lack of access to quality diagnostic tools and medicines further contribute to

[70] See www.who.int/tb/areas-of-work/population-groups/prisons-facts/en/; F. Biadglegne, A. Rodloff and U. Sack, "Review of the prevalence and drug resistance of tuberculosis in prisons: a hidden epidemic", *Epidemiology & Infection*, vol. 143, No. 5 (April 2015).

[71] G. Mburu and others, "Detention of people lost to follow-up on TB treatment in Kenya: The need for human rights-based alternatives", *Health and Human Rights Journal*, vol. 18, No. 1 (2016), abstract.

[72] Masoud Dara, Dato Chorgoliani and Pierpaolo de Colombani, "TB prevention and control care in prisons". Available from https://pdfs.semanticscholar.org/c9d4/e241b8d4204108df36c16ad4e7cea4d8e56f.pdf.

[73] Stop TB Partnership, Key Populations Brief: Prisoners. Available from www.stoptb.org/assets/documents/resources/publications/acsm/KPBrief_Prisoners_ENG_WEB.pdf.

prisons as tuberculosis incubators, with as few as 18 per cent of prisons in high-burden tuberculosis countries having access to such tools.[74]

91. Excessive hospitalization, in some cases in prison-like hospital conditions for multidrug-resistant (MDR) and extensively-drug resistant (XDR) tuberculosis, is also an issue of concern. Many countries default to isolation, particularly in the context of such drug-resistant strains of tuberculosis. This results in fear and mistrust in public-health systems and inadequately supports the realization of the right to health of people with tuberculosis. Prolonged isolation, used for lengthy treatment of such drug-resistant tuberculosis, has also shown to induce feelings of fear, anger, self-blame, depression and suicide; there have been similar findings among incarcerated individuals.[75] This is unsurprising, as persons with the disease perceive prolonged isolation as imprisonment.

B. Community-based care and tuberculosis

92. WHO recognizes that community-based care can achieve results comparable to those of hospitalization and may result in decreased nosocomial spread of tuberculosis, and emphasizes that community-based care should always be considered before isolation.[76] Forced isolation is unethical and is not in conformity with the right to health.

93. Despite the evidence, and ethical and rights-based considerations, some criminal laws provide for confinement and punitive practices as part of national responses to tuberculosis. While these may be perceived as "public-health" measures to stem the spread of the disease, they entail significant human rights violations and further harm public health, undermining efforts to effectively address the disease. Rather than relying heavily on confinement, a rights-based approach calls for the development of well-resourced community health-care options, ensuring that persons with tuberculosis have adequate information, nutritional support and income and other support while undergoing treatment and/or if tuberculosis results in a loss of employment. While underresourced, small-scale, innovative, community-based treatment models have proven extremely effective, with high treatment completion and cure rates.[77]

94. Confinement as a response to tuberculosis increases stigmatization of people with the disease, driving those most at risk underground and away from health care. Confining people with tuberculosis not only puts them at risk by placing them in settings often characterized by inadequate access to treatment and support, but also fuels the spread of the disease within these settings. As a particularly stark example, incarceration has been utilized to isolate persons with tuberculosis, punishing them for not adhering to the treatment, even though violations of the right to health led to their non-adherence in the first place. Confinement inappropriately places the burden of tuberculosis treatment and care on the person, effectively isolating and criminalizing those who are sick instead of providing the health care and support needed to complete treatment. These practices must be brought to an end.

VII. Conclusions and recommendations

95. **Deprivation of liberty and confinement, when they are used as widespread forms of addressing various social, and often non-criminal, issues, create an environment that is detrimental to the enjoyment of the right to physical and mental**

[74] Banuru Muralidhara Prasad and others, "Status of tuberculosis services in Indian prisons", *International Journal of Infectious Diseases*, vol. 56 (2017).

[75] Kingsley Lezor Bieh, Ralf Weigel and Helen Smith, "Hospitalized care for MDR-TB in Port Harcourt, Nigeria: a qualitative study", *BMC Infectious Diseases* (2017).

[76] WHO, *Guidelines on Ethics of Tuberculosis Prevention, Care and Control* (2010), pp. 11–12.

[77] See, for example, WHO, Regional Office for Europe, *Good Practices in Strengthening Health Systems for the Prevention and Care of Tuberculosis and Drug-resistant Tuberculosis* (Copenhagen, 2016). Available from www.euro.who.int/__data/assets/pdf_file/0010/298198/Good-practices-strengthening-HS-prevention-care-TBC-and-drug-resistant-TBC.pdf.

health. While reality is such that certain cases of imprisonment may always be justified, it is unacceptable that in the twenty-first century detention and confinement continues to be regularly used for minor offences and for addressing public-health issues.

96. It is unacceptable that States continue to use detention and confinement as a preferred tool to promote public safety, "morals" and public health, doing more harm than good to social justice, public health and the realization of the right to physical and mental health.

97. Sustainable Development Goal 3 on ensuring healthy lives and promoting well-being for all at all ages will not be reached if the global community neglects to seriously address the use of detention and confinement as a public-health policy and to prioritize the development of effective alternatives. This retains its importance at all stages of life, starting in early childhood, moving through adolescence and youth and providing opportunities for healthy and dignified aging in community-based settings.

98. The Special Rapporteur urges States to:

(a) Fully abide by, and implement, the Nelson Mandela Rules, in particular as regards the provision of health care in prisons;

(b) Redistribute funds that currently support detention and confinement on the basis of public safety and public health towards enhancing public-health systems that include safe and supportive schools, programmes to support healthy relationships, access to development opportunities and an environment free from violence;

(c) Develop measures to address, on a non-discriminatory basis, the barriers faced by people in prison and other settings of detention and confinement in gaining access to health care, particularly women, children, drug users, persons with disabilities and persons with tuberculosis;

(d) Enhance community-based facilities that empower and promote recovery and healthy relationships, while radically reducing and progressively eliminating non-consensual measures and institutionalization in mental health-care settings;

(e) Effectively provide reasonable accommodation for imprisoned persons with disabilities, particularly those with psychosocial or intellectual disabilities;

(f) Implement national strategies towards depenalization and non-custodial measures for children in conflict with the law or who are already imprisoned;

(g) Fully eliminate institutional care of children under 5 years of age and replace it with a comprehensive family-support system;

(h) Scale up investment to deinstitutionalize children of all ages confined on health or social-welfare grounds in large institutions, such as infant homes and closed social care and mental health facilities, particularly children from vulnerable groups, including ethnic minorities and indigenous populations, and children with disabilities;

(i) Implement policies and specific measures to avoid by all means the detention of children, including the development of alternative models and responses for incarcerated mothers;

(j) Repeal laws criminalizing access to, and information about, sexual and reproductive health-care services, including with regard to the prevention and termination of pregnancy and consensual adult sex;

(k) Effectively provide special accommodation for prenatal and postnatal care and treatment in prisons and detention centres, jointly with adequate and timely food and a healthy environment, free of charge, for pregnant women and breastfeeding mothers, in accordance with the Bangkok Rules;

(l) End the criminalization, incarceration and confinement of persons with tuberculosis as a public-health measure, while developing community-based services that ensure access to adequate information, nutritional support and income;

(m) **Implement measures to empower detained and confined persons to exercise meaningful autonomy and participate in health-care decisions, with appropriate support and accommodation where needed;**

(n) **Promote the participation of formerly or currently detained or confined persons and their families and civil society in accountability arrangements, while developing strategies within national human rights institutions and national preventive mechanisms for the inclusion of a right-to-health approach in monitoring and promotion functions.**

99. **The Special Rapporteur calls on the international community to scale up support for community-based interventions that effectively safeguard individuals from discriminatory, arbitrary, excessive or inappropriate confinement.**

100. **The Special Rapporteur urges other relevant stakeholders to include in debates on mental health the issue of the "insanity" defence and of other criminal justice tools, such as mental health courts and security measures, considering how they may reinforce systemic human rights failures in prisons and mental health settings.**

United Nations A/HRC/38/36/Add.1

General Assembly

Distr.: General
5 April 2018

Original: English

Human Rights Council
Thirty-eighth session
18 June–6 July 2018
Agenda item 3
Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on his mission to Indonesia

Note by the Secretariat

The Secretariat has the honour to transmit to the Human Rights Council the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Pūras, on his visit to Indonesia from 22 March to 3 April 2017.

Indonesia has made considerable progress with regard to the realization of the right to health, particularly by expanding universal health coverage. The Special Rapporteur encourages the Government to address a number of serious challenges that remain connected to the existing normative and policy framework and its implementation. He assesses the national health system and the mental health framework and warns of the prevalence of inequalities and discrimination against certain populations and groups, particularly women, persons living with HIV/AIDS and persons who use drugs. The Special Rapporteur makes a number of action-oriented recommendations.

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Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on his mission to Indonesia*

Contents

		Page
I.	Introduction	3
II.	Right to health framework	3
	A. Background	3
	B. Normative and institutional framework	4
	C. National health-care system	6
III.	Mental health	9
IV.	Key populations and groups	11
	A. Women and girls	12
	B. Persons living with HIV/AIDS	17
	C. Persons who use drugs	18
V.	Conclusions and recommendations	20

* Circulated in the language of submission only.

I. Introduction

1. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Pūras, visited Indonesia from 22 March to 3 April 2017 at the invitation of the Government. The purpose of the visit was to ascertain, in a spirit of dialogue and cooperation, how the country implements the right to health.

2. During his visit, he met with high-ranking Government officials, members of the parliament and staff of relevant health-related institutions at the central, provincial and local levels. He had meetings with the *Komnas HAM* (National Human Rights Commission), the *Komnas Perenpuan* (National Commission on Violence against Women) and the *Komisi Perlindungan Anak Indonesia* (Indonesia Child Protection Commission). He also met with representatives of international organizations, the diplomatic corps and a wide range of civil society actors, including health-care professionals.

3. The Special Rapporteur visited health facilities at different levels in Jakarta, Padang, Labuan Bajo and Jayapura, including health posts, *puskesmas* (primary health-care centres), general hospitals and psychiatric units, a mental-health hospital, HIV/AIDS clinics and a drug rehabilitation clinic. He also visited two education centres for health workers.

4. The Special Rapporteur is grateful to the Government of Indonesia for its invitation and full cooperation during his visit. He appreciates the important support provided by the United Nations country team, including the Joint United Nations Programme on HIV/AIDS, the United Nations Population Fund, the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO).

II. Right to health framework

A. Background

5. Indonesia gained independence from the Netherlands in 1945, bringing most of territories of the former Dutch East Indies under its sovereignty. Following independence, the country was ruled by a succession of authoritarian regimes that exercised centralized control. The collapse of military rule in 1998, during the Asian financial crisis, triggered important reforms at various levels, including a decentralization process.

6. Indonesia is a diverse archipelago nation spread over a territory of nearly 2 million km^2, with a population of over 250 million drawn from more than 300 ethnic groups. Its distinct geographical condition and vast cultural diversity are important factors that must be taken into account when designing and delivering public policies and services.

7. Since the 1990s, the country has achieved impressive economic growth, with gross domestic product (GDP) per capita rising steadily, from $857 in 2000 to $3,603 in 2016,[1] and has become the largest economy in South-East Asia. Today, it is the fourth most populous nation in the world and an emerging middle-income economy that has managed to halve poverty over the past two decades, to 10.9 per cent in 2016.[2]

8. Indonesia has concentrated its efforts in the fields of economic growth and development on infrastructure development and social assistance, including programmes related to health care and education, with a particular focus on persons living in poverty. With a strong commitment to public health, the country has made significant progress in improving the health status of its population, including life expectancy and the incidence of communicable diseases, such as malaria and tuberculosis.

[1] See www.worldbank.org/en/country/indonesia/overview.

[2] Ibid.

9. The health sector has developed with a strong focus on primary care and universal access for the poorer sectors of the population. Considerable sums have been invested in efforts to develop health infrastructure, make services available and accessible and address the underlying determinants of health, including poverty, education and food and nutrition, through different policies and programmes.

10. Since the 1990s, there has been considerable improvement regarding most of the targets of the Millennium Development Goals, with Indonesia achieving 49 out of 67. However, target 5.A of the Millennium Development Goals was not among those achieved and neonatal, infant and under-5 mortality rates remain high.

11. In recent years, the continued decline of the global demand for commodities has led to moderate economic growth. During this time, job creation and poverty reduction have slowed down, contributing to the reinforcement of inequalities and compounded forms of discrimination, particularly among groups in vulnerable situations.

12. More than 28 million Indonesians still live below the poverty line and around 40 per cent of the population is at risk of falling into poverty. The gap between rich and poor has increased in recent years and may further widen. At 0.40, the Gini coefficient of Indonesia, a measure of inequality, is higher than that of neighbouring countries.[3]

13. Despite commendable efforts and sustained investment, availability, access to, and quality of health services remain a challenge in a country where the population is spread across thousands of islands, some located in remote and hard-to-reach areas. The Government has launched an agenda for developing Indonesia from the periphery that focuses on advancing the rights and welfare of persons living in remote and border regions.[4]

14. Indonesia has been actively involved in the 2030 Agenda for Sustainable Development and the Sustainable Development Goals since their inception and took part in the 2017 high-level political forum on sustainable development voluntary national review process. The National Medium-Term Development Plan 2015–2019 has been aligned with the targets of the Sustainable Development Goals and contains three development dimensions, including a human-development dimension comprising education, health and housing.[5]

15. Nonetheless, Indonesia must effectively address high maternal, infant and under-5 mortality and morbidity rates, inequalities, poverty and significant disparities between urban and rural areas. It is essential in this regard to improve integrated data management, institutional coordination and the availability and quality of health-related data.

B. Normative and institutional framework

16. Indonesia joined the United Nations in September 1950 and has ratified and acceded to almost all the international human rights treaties, except for the International Convention for the Protection of All Persons from Enforced Disappearance and the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. The country has ratified the two Optional Protocols to the Convention on the Rights of the Child on the involvement of children in armed conflict and on the sale of children, child prostitution and child pornography.

17. Indonesia has not accepted the complaints procedures under any of the international human rights treaties, a situation which seriously undermines access to remedies for victims

[3] Ibid.

[4] See A/HRC/36/7, para. 11.

[5] Indonesia, "Voluntary national review (VNR): eradicating poverty and promoting prosperity in a changing world", 2017, p. 1. Available from https://sustainabledevelopment.un.org/content/documents/15705Indonesia.pdf.

and accountability with regard to respect, protection and fulfilment of the right to health.[6] Between 2015 and 2017, Indonesia was a member of the Human Rights Council.

18. The country has received visits by the Special Representative of the Secretary-General on human rights defenders, in 2007, the Special Rapporteur on adequate housing as a component of the right to an adequate standard of living, and on the right to non-discrimination in this context, in 2013, and the United Nations High Commissioner for Human Rights, in February 2018. At present, Indonesia has 20 outstanding visit requests from different mandate holders and is yet to issue a standing invitation to the special procedures of the Human Rights Council.

19. Indonesia has not ratified the WHO Framework Convention on Tobacco Control or the Indigenous and Tribal Peoples Convention, 1989 (No. 169) and the Domestic Workers Convention, 2011 (No. 189) of the International Labour Organization.

20. In May 2017, the human rights situation in Indonesia was considered as a part of the third cycle of the universal periodic review. Prior to this process, the Committee on Economic, Social and Cultural Rights and the Committee on the Elimination of Discrimination against Women had both reiterated their concerns about a lack of clear definition and of a normative framework to prohibit and combat discrimination on all grounds. Both Committees highlighted the existence of deeply discriminatory by-laws, including in Aceh, restricting women's rights in the conduct of their daily life but also the rights of other sectors of the population, such as children, sex workers and lesbian, gay, bisexual and transgender persons.[7]

21. The report of the Working Group on the Universal Periodic Review (A/HRC/36/7) contained a number of health-related observations and recommendations that enjoyed the support of Indonesia, including a number related to: enhancing the coverage of and access to health services, particularly in rural and remote areas; adopting legislative and policy measures to ensure that women and adolescents have access to sex education and reproductive health services; expediting the adoption of the draft law on gender equality; strengthening measures to protect and promote the rights of persons with disabilities; and promoting the rights of women and children and the need to continue the fight against domestic violence.

22. Indonesia will examine a number of health-related universal periodic review recommendations with a view to providing responses in due time, including recommendations related to: drug policy and the imposition of the death penalty for drug offences; access to sexual and reproductive health services, including contraception and family planning, for women regardless of their marital status; and the prohibition of all forms of female genital mutilation.

23. At the regional level, Indonesia has launched important health-related initiatives, particularly with regard to the eradication of malaria and the fight against HIV/AIDS.

24. Pursuant to article 28 (h) of the Indonesian Constitution (1945), last amended in 2002, every person has the right to physical and spiritual prosperity, to have a home, to enjoy a good and healthy environment and to obtain medical care. Article 34 establishes the right to have access to a social security system, particularly for those in most need.[8]

25. Law No. 36 on health (2009) contains general provisions, principles and objectives relating to health and the rights and obligations of all persons with regard to health care. It establishes that the Government has a responsibility to provide health care, ensure resources for the health sector and strive to realize the highest possible level of health for the population.

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[6] Indonesia has yet to ratify the Second Optional Protocol to the International Covenant on Civil and Political Rights, aiming at the abolition of the death penalty.

[7] See E/C.12/IDN/CO/1, para. 6 and CEDAW/C/IDN/CO/6-7, para. 17.

[8] See www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_174556.pdf.

26. The *Komnas HAM* was established in 1993 through a presidential decree that was superseded by law No. 39 (1999), which set out its functions and provided for its funding, membership and powers. Law No. 26 on human rights (2000) granted the *Komnas HAM* the power to investigate alleged human rights abuses. In 2008, law No. 40 gave the *Komnas HAM* additional responsibilities concerning the prevention of racial and ethnic discrimination. The body has been accredited with A status by the Global Alliance of National Human Rights Institutions ever since 2000 and is active in the field of health-related issues.

27. Several public policies, programmes and initiatives stem from this normative and institutional framework, including the Healthy Indonesia and Nusantara programmes and the health components of the National Action Plan on Human Rights 2015–2019. In line with the national development plan, Indonesia has developed its health strategy for the period 2005–2025, which prioritizes maternal health and the prevention of non-communicable diseases.

C. National health-care system

28. The current national health system stemmed from the previous *Jamkesmas* system, established in 2007 and directed at those segments of the population living in or at risk of poverty and lacking health insurance. The system is fully financed out of central Government revenues, administered by the Ministry of Health and regulated by law No. 40 on the national social security system (2004) and law No. 24 on social security agencies (2011).

29. Indonesia has mixed public-private provision of health-care services, with the public sector playing the dominant role, especially in rural areas and for secondary levels of care. Public health-care provision is decentralized to the district level within the framework of law No. 23 (2014), which established that both central and regional governments must allocate funding for the provision of health services.[9] Nonetheless, the central Government remains the dominant source of overall financing of the health sector, but district governments have discretion over how budgets are allocated and how much gets spent on health.[10] Physical access to health services in Indonesia is considered adequate, although there are shortages in the number of, and uneven distribution of, health professionals.

30. In the context of South-East Asia, Indonesia spends relatively little on health services. In 2014, the regional average for total expenditure on health as a percentage of GDP was 4 per cent. In Indonesia, it was 2.85 per cent of GDP, compared to 4.17 per cent in Malaysia, 4.7 per cent in the Philippines and 4.1 per cent in Thailand. Out-of-pocket expenditure as a percentage of private expenditure on health remains high in Indonesia: in 2014, it comprised around 75 per cent of private expenditure on health, compared to 78 per cent in Malaysia, 81 per cent in the Philippines and 53 per cent in Thailand. Per capita expenditure on health in 2015 (at average exchange rate) was $111.8, compared to $385.6 in Malaysia, $126.9 in the Philippines and $217.1 in Thailand.[11]

The path to universal health coverage

31. The *Jamkesmas* programme had a number of successes, including providing coverage for over 40 per cent of poor and near-poor households; increasing outpatient and inpatient utilization rates among *Jamkesmas* programme cardholders; reducing levels of

[9] See www.indolaw.org/UU/Law%20No.%2023%20of%202014%20on%20Local%20Government.pdf.

[10] Peter Heywood and Nida P. Harahap, "Public funding of health at the district level in Indonesia after decentralization — sources, flows and contradictions", Australia and New Zealand Health Policy, vol. 6, No. 13 (April 2009). Available from www.researchgate.net/publication/24282382_Public_funding_of_health_at_the_district_level_in_Indonesia_after_decentralization_-_Sources_flows_and_contradictions.

[11] World Health Organization (WHO) Global Health Observatory data repository, health financing. Available from http://apps.who.int/gho/data/node.main.GHEDCHEpcUSSHA2011?lang=en.

catastrophic expenditure; and increasing the participation of private providers. However, the system was reviewed as a result of significant shortcomings,[12] including: the lack of coverage for nearly 60 per cent of the population, including in the informal sector; high out-of-pocket expenditure, even among persons enjoying coverage; the lack of equitable access to good quality health services in remote rural areas; low levels of awareness of benefits; and a low rate of utilization of health services. Additionally, the programme was known for its poor accountability mechanisms.[13]

32. Indonesia has made a bold, ambitious and commendable commitment to develop a universal health-care insurance system and to achieve universal health coverage by 2019. Health sector interventions designed to support poverty alleviation efforts and improve welfare have been conducted with a view to improving the health status of the population, focusing on, among other things: maternal, infant and under-5 mortality rates; coverage regarding reproductive health services; the control of communicable and non-communicable diseases; the expansion of the national social security system; equal distribution of health personnel; and provision of medicines and vaccines at the community level.[14]

33. Efforts to implement universal health coverage began in January 2014, through a system managed by the Social Insurance Administration Organization — (Healthcare). The national health insurance system uses a single-payer system, with the Social Insurance Administration Organization as the sole mechanism, known as the *Jaminan Kesehatan Nasional* (national health insurance system). The national social security system was implemented through the issuing, by the *Jaminan Kesehatan Nasional*, of the Healthy Indonesia Card. By the end of 2016, 66.4 per cent of the total population, including 40 per cent of those persons in the lowest income bracket, had been covered.[15]

34. Private health practitioners' engagement with the public sector through universal health coverage is being promoted by the Government in order to improve access to health-care services. However, there is a need to define roles and functions within the health system at the different levels of Government in the areas of human resources for health and sector performance, as well as to increase and redirect health-sector financing and determine how health institutions could develop to foster effective community and service users' participation.[16]

Primary care as a priority in strengthening the health-care system

35. Basic primary health care in Indonesia is provided by a public network of *puskesmas*, each serving a catchment area of about 25,000–30,000 individuals: a level of provision which is regarded as being relatively adequate. According to official information, there are 9,767 *puskesmas* and each one is supposed to be staffed by a minimum of nine different types of health professional, namely: doctor, dentist, nurse, midwife, public health official, environmental health official, nutritionist, pharmacist and health analyst. However, by 2016, only about 1,200 *puskesmas* met the above-mentioned health personnel standard.[17]

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[12] The World Bank, "Key lessons learned from Jamkesmas to achieve universal health care in Indonesia", 30 January 2014. Available from www.worldbank.org/en/news/feature/2014/01/30/improving-jamkesmas-to-achieve-universal-health-care-in-indonesia.

[13] Pandu Harimurti and others, "The nuts & bolts of Jamkesmas: Indonesia's Government-financed health coverage program", Universal Health Coverage (UNICO) Studies Series 8 (World Bank, Washington, D.C., January 2013), pp. 8–9 and 20–22. Available from http://documents.worldbank.org/curated/en/430821468044119982/pdf/749960REVISED00000PUBLIC00Indonesia1.pdf.

[14] Indonesia, "Voluntary national review", p. ix. Available from https://sustainabledevelopment.un.org/content/documents/15705Indonesia.pdf.

[15] Ibid., p. viii.

[16] WHO Country Cooperation Strategy 2011–2017. Available from http://apps.who.int/iris/bitstream/handle/10665/136896/ccsbrief_idn_en.pdf;jsessionid=E2C142557D58D951BBBDBCFB20A2F176?sequence=1.

[17] Indonesia, "Voluntary national review", p. 38. Available from https://sustainabledevelopment.un.org/content/documents/15705Indonesia.pdf.

About a third of *puskesmas* also provide inpatient services. Significant discrepancies in geographic accessibility remain a challenge, with persons living in remote inland areas or on small islands having particularly poor access to health-care services.

36. In principle, *puskesmas* should provide referrals to secondary and tertiary public hospitals. However, in practice, the gatekeeping and referral functions of *puskesmas* are weak. There are no effective mechanisms for dissuading patients from self-referring to a higher-level facility: patients can go directly to secondary or tertiary hospitals without referrals or simply obtain a referral letter from the *puskesmas*.

37. The existing primary health-care system is an impressive network of infrastructure that needs to be supported and improved so that most health conditions are effectively managed at the primary care level and only complicated cases are referred to specialists and hospitals. Moreover, the primary health-care system and the Social Insurance Administration Organization should not only serve the poor but should also win the trust of the more affluent sectors of society. This is an important precondition for the sustainability of any universal health-care system.

38. Consolidating primary care is a good basis for achieving full coverage. However, significant challenges remain regarding equitable access to and the quality of services throughout the country, as well as a lack of good governance and incentives for managing the different levels of care in such a way as to encourage the use of primary care.

39. The roles of general practitioners, nurses, social workers and health assistants should be strengthened by building their capacities and competencies through continuous-learning programmes. Innovative incentives to consolidate the position of general practitioners as health-care system "gatekeepers" should be considered.

Regional inequities in access to good-quality health care

40. A particular challenge faced by the Indonesian health-care system is linked to the distinct and complex geographical and regional disparities in terms of socioeconomic indicators and infrastructure, which particularly affect persons living in the eastern part of the country and on remote islands.

41. Availability of and access to health-care services have improved over the past decades with the extension of health coverage through increased infrastructure, staffing and financing. The Special Rapporteur visited the eastern part of the country, including Labuan Bajo and Papua, and noted some of the public initiatives to address the above-mentioned disparities. The Nusantara programme is aimed at developing primary health-care services in border and underserved areas and a scheme has been drawn up under which specialist doctors complete a period of compulsory service in such areas.

42. However, the Special Rapporteur was apprised of some of the challenges to ensuring access to good-quality health-care services for the population in the eastern provinces of the country, particularly for those living on the Lesser Sunda Islands and Papuans living in remote regencies (administrative subdivisions) in the highlands. He noted with concern that preventable and treatable diseases (respiratory-tract infections, measles, diarrhoea and dysentery) claim a high number of victims and affect the most vulnerable members of communities, particularly children.

43. With regard to Papua, the Special Rapporteur was informed that, pursuant to the special autonomy framework (laws No. 21 on special autonomy for Papua Province (2001) and No. 35 amending law No. 21 on special autonomy for Papua Province to include West Papua Province (2008)), Papua and West Papua Provinces receive larger health-budget allocations than any other province. Nonetheless, he expresses regret at the roseola epidemic that affected nine villages in Deiyai Regency between April and July 2017 and the outbreak of pertussis (whooping cough) in Nduga Regency in November 2015.[18] While in Jayapura, the Special Rapporteur met with representatives of local communities and ethnic Papuans and gathered information and testimonies on the main challenges to

[18] See A/HRC/33/32, p. 61.

accessing good-quality health care. Most villages in remote regencies in the highlands suffer from a lack of health centres, medical equipment and qualified medical personnel. General vaccination and immunization services are not consistently provided, there are no adequate monitoring mechanisms and public health services are not delivered in an equitable manner. It is reported that military personnel have been deployed in the context of outbreaks of disease. Overall, there is a lack of trust in the health services available and ethnic Papuans experience stigmatization and discrimination in health-care settings.

44. The authorities should continue to improve access to good-quality health care and to build the capacity of health structures in remote regions. Members of *Adat* (customary) communities, including indigenous Papuans, should have full access to public health facilities, goods and services, as well as to facilities, goods and services relating to the underlying determinants of health, such as safe and potable water and adequate food and sanitation. The collection and use of disaggregated data are crucial to efforts to achieve this goal. Culturally appropriate health-promotion tools and information should be developed and disseminated to prevent communicable and non-communicable diseases, particularly in remote areas. Members of *Adat* communities, including ethnic Papuans, should be trained as health-care workers, accredited as medical practitioners and integrated into the health-care system at all levels. Health-care curricula should include the training of health-care workers to deliver culturally appropriate services.

Current challenges facing the system

45. While there are important managerial and economic issues to be addressed concerning the current system, the Special Rapporteur wishes to highlight other important issues which should not be ignored by policymakers in the health and related sectors. These concern the principles of non-discrimination, accountability, participation, empowerment and informed consent and the need to go beyond the narrow biomedical model so that Social Insurance Administration Organization participants are provided with holistic, equitable and ethical care.

46. The focus on reaching the poor, addressing financial exclusion and mitigating catastrophic expenditures should not undermine the attention given to structural and systemic challenges stemming from deeply entrenched patterns of discrimination on other grounds, such as ethnicity, sex, religion, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, gender identity and legal status.

47. Mutual trust among all participants in the universal health-care insurance system is a decisive element of success. It is the best remedy against fraud, corruption, discrimination and stigmatization and disparities and imbalances within the health-care system.

48. In Indonesia, regional disparities should be addressed to avoid disproportionate allocation of Social Insurance Administration Organization health funds to urban areas and the eastern regions of the country. Mental health should be addressed as an important part of general health through the development and reimbursement of modern mental health services under basic primary care schemes. Reproductive health services need to be scaled up, with particular focus on adolescents and youth. Current trends relating to morbidity and mortality, with rates of non-communicable diseases rising and those of communicable diseases remaining high, need to be addressed in a creative manner.

49. These and other challenges can only be effectively addressed if all elements and principles of the right to health framework are mainstreamed into health policy formulation and implementation, including non-discrimination, equality, participation and accountability.

50. National budget allocations for health should be increased and out-of-pocket payments reduced. However, increased investments in the health-care system only make sense if the system is efficient, transparent, user-friendly and -responsive. For health-care systems to be efficient, sustainable investment in primary care must be given top priority.

51. While the Special Rapporteur commended the efforts made to invest in training of front line health-care workers, he wishes to underline that substantial investment is needed to improve the quality and increase the number of health-care workers. Skills training for

and geographical deployment, with innovative incentives, of doctors and other health-care workers remain a challenge.

III. Mental health

52. A number of major initiatives have been launched regarding mental health care, including provisions for the integration of basic mental health into general health services, the building of human-resources capacity, ensuring the availability of affordable drugs and accessible community-based services.[19] The Special Rapporteur visited Suharto mental health hospital and familiarized himself with the approach and level of public sector mental health professionals.

53. Specific guidelines have been developed by health officials for the implementation of rights-based mental health services and programmes, including training programmes for primary care physicians on the management and development of health-care facilities and services. However, as at 2011, most primary care doctors and nurses had not received updated official in-service training on mental health.[20] Additionally, there are stark disparities regarding different geographical access and availability of mental health services and facilities, particularly affecting persons living in rural and remote areas.

54. There are an estimated 600–800 trained psychiatrists in Indonesia, or 1 per 300,000–400,000 inhabitants. The country has 51 mental hospitals, serving 16,056 islands, including 32 public hospitals and 19 private hospitals located across 4 of the 34 provinces. Out of the 51 mental hospitals, an estimated 22 provide specialized services such as child psychiatry.[21] Moreover, only 249 of a total of 445 general health-care institutions offer any form of mental health-care services.[22]

55. The Special Rapporteur is extremely concerned about information received regarding living conditions in most health centres and social care institutions indicating overcrowding, involuntary treatment and the use of forced seclusion as a form of punishment or discipline.[23] Involuntary treatment and other psychiatric interventions in health-care facilities may constitute torture and ill-treatment.[24]

56. Law No. 18 on mental health (2014) mandates every province to have its own mental hospital (art. 52) and every district and municipality to build or support the establishment of at least one community-based service facility outside the mental health care sector (art. 58).[25] However, law No. 18 on mental health is problematic in its definition and application of the principle of informed consent and coercion, which perpetuates power imbalances in care relationships.

57. Law No. 18 justifies using coercion based on the principles of medical necessity, the fact that the person concerned may be incompetent or dangerous and the need to help that person overcome obstacles in carrying out functions as a human being. In such conditions of "incompetency", law No. 18 authorizes family members or guardians to take medical decisions on behalf of the person concerned without judicial review, including regarding admission to a mental health facility and the administering of treatment without consent.[26] The person admitted cannot appeal against his or her admission or leave the facility in question until he or she has been administratively discharged.

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[19] Law No. 18 on mental health (2014), arts. 7, 25, 26, 34–35, 40 and 79.

[20] See www.who.int/mental_health/evidence/atlas/profiles/idn_mh_profile.pdf.

[21] ASEAN Secretariat, *ASEAN Mental Health Systems* (Jakarta, 2016), p. 43. Available from http://asean.org/storage/2017/02/55.-December-2016-ASEAN-Mental-Health-System.pdf.

[22] Human Rights Watch "Living in hell: abuses against people with psychosocial disabilities in Indonesia" (March 2016). Available from www.hrw.org/report/2016/03/20/living-hell/abuses-against-people-psychosocial-disabilities-indonesia.

[23] Ibid.

[24] See A/HRC/22/53, para. 64 and A/63/175, para. 50.

[25] See http://jakartaglobe.id/news/indonesian-mental-health-law-passed-five-years/.

[26] Law No. 18 on mental health (2014), art. 21.

58. Informed consent is a core element of the right to health, both as a freedom and as an integral safeguard to the enjoyment of that right (A/64/272). The right to provide informed consent to treatment and hospitalization includes the right to refuse treatment (see E/CN.4/2006/120, para. 82).

59. States should fully integrate a human rights perspective into mental health and community services and adopt, implement and monitor all existing laws, policies and practices with a view to eliminating all forms of discrimination, stigma, violence and social exclusion within that context (Human Rights Council resolution 36/13 on mental health and human rights).

Persons with intellectual and psychosocial disabilities

60. The right to health is now understood within the framework of the Convention on the Rights of Persons with Disabilities. Immediate action is therefore required to radically reduce medical coercion and facilitate the move towards an end to all forced psychiatric treatment and confinement.

61. The Special Rapporteur acknowledges the significant progress made with regard to legislative provisions that uphold the rights of persons with disabilities in the form of law No. 8 on persons with disabilities (2016). The law provides for the strengthening of legal frameworks and institutional capacity and the development of monitoring and evaluation mechanisms that affect the daily lives of persons with disabilities. It also outlines provisions on the formulation of follow-up laws and implementing regulations at the provincial and local levels, including Presidential and Ministry of Social Affairs regulations.[27]

62. However, this law is not in full conformity with the Convention on the Rights of Persons with Disabilities as, for example, it fails to recognize the legal capacity of persons with disabilities. Furthermore, while the law contains provisions on the reproductive health rights of persons with disabilities, including specific provisions on the protection of women and girls with disabilities who are victims of sexual violence,[28] it is silent on the subject of law No. 1 on marriage (1974), pursuant to which uncured illness and a wife's disability are legitimate grounds for divorce and polygamy.[29]

63. In 2011, the Government launched a campaign to end the degrading and violent practice of shackling that led to clear policies, guidelines and efforts in that regard. Initiatives in that field have focused on raising awareness about mental health, integrating mental health care into primary health care, providing mental health medication at the public health centre level and training health staff to identify and diagnose basic mental health conditions. Community mental health teams have been created by the Government to conduct community outreach activities, including identifying and rescuing persons held in shackles. As of 2015, some 8,690 persons with mental disabilities across 19 provinces were found to be shackled; of those cases, 7,961 have been addressed, with medical treatment being provided.[30]

64. The capacity of health structures in remote regions should be strengthened and they should be oriented towards community-based services and supported through substantial budget allocations, the adequate training of their staff and the empowerment of persons with psychosocial disabilities. The role played by primary health structures and general practitioners and their teams is essential. An integrated approach is required to prevent shackling being replaced with other forms of restraint and confinement which violate human rights.

[27] See http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=INT%2fCRPD%2fICO%2fIDN%2f27065&Lang=en.

[28] Law No. 8 on persons with disabilities (2016), arts. 5 (2) and 125–127.

[29] See www.cambridge.org/core/books/sharia-and-politics-in-modern-indonesia/the-law-of-the-republic-of-indonesia-number-1-of-the-year-1974-on-marriage/C93550E393785D7F1BBA9EA3385C34E90.

[30] See http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD%2fC%2fIDN%2f1&Lang=en.

IV. Key populations and groups

65. Inequalities in the enjoyment of the right to health in Indonesia are experienced in the form of barriers hindering access to and affecting the quality of essential services. This situation disproportionally affects groups in situations of poverty and persons living on small, remote islands and in the eastern provinces.

66. Additionally, certain population groups face discrimination and specific challenges in realizing their right to health, such as women and girls, persons who use drugs and persons living with HIV/AIDS.

A. Women and girls

Maternal mortality and morbidity

67. The country has significantly raised the life expectancy of certain sectors of the population and reduced child mortality rates over the past decades. The completion of the maternal and neonatal tetanus immunization programme in May 2016 is commendable.[31]

68. Government regulation No. 61 on reproductive health (2014) represented a step forward regarding efforts to address reproductive health issues. In 2015, the Ministry of Health endorsed a national action plan on maternal health for the period 2016–2030. However, while under-5 mortality has been halved since the 1990s, the maternal mortality rate has remained among the highest in the region, at 305 deaths per 100,000 live births in 2015,[32] with maternal health in Papua, Sulawesi, Maluku and Nusa Tengarra Provinces lagging behind other parts of Indonesia.[33] Reports indicate that most maternal deaths are the result of complications during pregnancy, unsafe delivery practices, early pregnancies and poor childbirth and postnatal care, including low levels of competence of birth attendants and poor access to family planning services. Other underlying causes include variations in the availability of and access to good quality referral systems for obstetric care in emergencies, particularly in remote areas.

69. The situation is aggravated by an extremely restrictive normative framework for the interruption of pregnancies, which criminalizes abortion and the provision of information on or advice specific to abortion in all circumstances. Women and girls who undergo an abortion face imprisonment. According to article 346 of the Penal Code, health professionals can be penalized for performing illegal abortions, with sentences of up to 10 years' imprisonment. Women and girls seeking an abortion may be imprisoned for up to 4 years.[34]

70. Under law No. 52 on population growth and family development (2009) and articles 299 and 346–349 of the Penal Code, abortion is permitted only where the life of the mother or of the fetus is at risk or where pregnancy is the result of rape. However, the laws infringe on dignity and autonomy by restricting decision-making by women and girls in respect of their sexual and reproductive health. Legal requirements such as the obtaining of consent from the husband or, in the case of rape, a doctor's letter and an official statement from a police investigator, psychologist or other expert regarding the alleged rape and documents relating to the counselling process, have made medical coercion common.[35] Paternalistic legislation and a lack of alternatives mean that access to safe abortion and post-abortion

[31] See http://indonesia.unfpa.org/en/news/indonesia-has-eliminated-maternal-and-neonatal-tetanus.

[32] See http://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/IDN/INT_CEDAW_IFN_IDN_26445_E.pdf.

[33] Wide disparities exist regarding the under-5 mortality rate, which, in 2012, stood at 115 deaths per 1,000 live births in Papua and 28 per 1,000 in Riau. See https://pdf.usaid.gov/pdf_docs/pnaca447.pdf; see also, Country Programme Action Plan 2016–2020 Government of Indonesia/United Nations Population Fund, *Programme of cooperation between the Government of Indonesia and the United Nations Population Fund*, (Jakarta, 2016).

[34] Amnesty International, *Left without a choice. Barriers to reproductive health in Indonesia* (2010), p. 33. Available from www.amnesty.org/download/Documents/36000/asa210132010en.pdf.

[35] Law No. 36 on health (2009), arts. 75–76.

care is extremely limited, especially for poor and young women.[36] As a result, abortions are performed in clandestine locations, causing grave health complications that lead to the deaths of many girls and young women every year.[37]

71. The strong social stigma attached to premarital sex further discourages unmarried women and girls from seeking to obtain access to antenatal and postnatal services and leaves them at risk of unwanted pregnancies, sexually transmitted diseases, unsafe abortion and exploitation.

72. Law No. 36 on health (2009) provides that the Government shall issue specific guidelines for doctors and health professionals on the provision of abortion services in the event of pregnancies that are life-threatening or in cases of rape, without discrimination against and fully respecting the right to privacy of victims of rape. Despite the authorities' efforts, awareness regarding the legal status of abortion is not yet widespread, either among women or among health professionals.

Sexual and reproductive health and rights

73. According to reports, there are more than 65 million young persons aged between 10 and 24 years in Indonesia, representing about 28 per cent of the population.[38] Approximately 5 per cent of adolescents aged between 12 and 19 years report having had sexual relations, of which 83 per cent did so before the age of 14 years. More than half of those relations occurred without planning, with 34 per cent reporting having using modern contraceptive methods, such as condoms.[39]

74. Positive initiatives have been launched to create a supportive environment for young persons' sexual and reproductive health, such as the incorporation of adolescent sexual and reproductive health in the National Action Plan on School Aged Child and Adolescent Health 2017–2019. National health and family planning policies and programmes have incorporated adolescent sexual and reproductive health in order to promote the coordinated delivery of adolescent-friendly health services in public health centres to protect young persons from and prevent risks related to their sexual and reproductive health.[40] However, punitive laws and restrictive interpretations of religious and cultural values and beliefs limit the delivery of comprehensive sexual and reproductive health services, including family planning and contraceptive methods, to young persons, adolescents and unmarried adults, and those population groups' access to such services (law No. 52 on population growth and family development (2009) and law No. 36 on health (2009)).[41]

75. Many adolescents, particularly girls and those identifying as lesbian, gay, bisexual and transgender, are deterred from approaching health professionals for fear of being judged according to social norms or laws that stigmatize or criminalize their sexual behaviour.

76. Comprehensive sexuality education is not properly integrated into school curricula in Indonesia. Related educational programmes are often limited to biology, physical education and procreation, and do not address human rights concepts, sexuality, gender identity or sex characteristics, including non-conforming gender identities. Educational programmes also have a stronger emphasis on abstinence as a means of avoiding sexually

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[36] Amnesty International, *Left without a choice: Barriers to reproductive health in Indonesia (2010)*, pp. 35–36. Available from www.amnesty.org/download/Documents/36000/asa210132010en.pdf.

[37] See Ministry of National Development Planning, *The Roadmap to Accelerate Achievement of the MDGs in Indonesia* (2010), p. 123. See also National Development Planning Agency, *Report on the Achievement of Millennium Development Goals: Indonesia, 2007* (2007), p. 52.

[38] See www.unicef.org/indonesia/children_2834.html.

[39] See www.who.int/ncds/surveillance/gshs/GSHS_Country_Report_Indonesia_2007.pdf?ua=1 and www.who.int/ncds/surveillance/gshs/UNICEF-GSHC-Report-Oct-07.pdf.

[40] Statistics Indonesia, *Indonesia Demographic and Health Survey: 2012: Adolescent Reproductive Health* (2013). Available from https://dhsprogram.com/pubs/pdf/FR281/FR281.pdf.

[41] United Nations, "United Nations country team Indonesia: report for the universal periodic review of Indonesia, twenty-seventh session", April–May 2017.

transmitted infections and unintended pregnancies than on the provision of comprehensive and evidence-based information to young persons and adolescents.

77. There is a need to expand the coverage and improve the quality of age-appropriate, comprehensive sexuality education, and to include therein the promotion of gender equality and respect for human rights, in order to better address the needs of all children and young persons, prevent early pregnancy and sexually transmitted infections and cater for the needs of persons living with HIV/AIDS, minors who may not be in education and persons who do not conform to gender norms.

78. The sexual and reproductive health services most needed, particularly among girls and young women, include: access to safe, reliable, affordable and good-quality contraception; comprehensive maternal health services; safe abortion and treatment for complications arising from unsafe abortion; and prevention and treatment of sexually transmitted infections and HIV/AIDS (see E/CN.9/2014/4, paras. 68–77). These services should be provided irrespective of age, marital status, sexual orientation or gender identity. Evidence shows that access to comprehensive sexuality education has a positive impact on the knowledge and health-related behaviours of adolescents and youth, and on their attitudes towards gender equality (see E/CN.9/2014/4, para. 68).

Gender-based violence

79. Gender-based violence, including violence against girls, women and transgender persons, was flagged as being an issue of grave concern. Reports indicate widespread prevalence of physical, sexual, emotional and economic violence (not allowing a person to work or confiscating a person's money), with 2 in 5 Indonesian women (or over 41 per cent) having experienced at least one of these four types of violence in her lifetime.[42]

80. Domestic violence at home and in the context of personal relationships constitutes an overwhelming majority of the reported cases involving sexual violence, including rape, with over 33 per cent of women aged between 15 and 64 years having reportedly experienced intimate partner violence or non-partner sexual violence.[43] However, it is estimated that the figures reported represent only the tip of the iceberg, as violence remains widely underreported, owing to prevailing patriarchal gender norms and associated stigma, and that the scope and enforcement of the existing legal provisions remains unsatisfactory.

81. Several laws and policies have been adopted to strengthen the legal framework on the protection of children from violence, including presidential instruction No. 5 on the national movement to eliminate sexual crimes against children (2014) and the national child-protection strategy for the period 2015–2019. The Special Rapporteur welcomes the inclusion of the bill on the elimination of sexual violence on the priority list of the 2017 national legislation programme for discussion in the parliament. He trusts that the bill will be passed as a matter of priority, in order to further advance the right to health, in line with the Sustainable Development Goals relating to women and girls.

82. While the country is taking important steps to strengthen data-collection and statistical systems to meet international standards, there is a need to improve the availability of high-quality data on violence against women to better inform public policies and action. The first nationally led survey on violence against women, conducted in 2016, constitutes a significant step in this direction.

83. The Special Rapporteur was apprised of the deeply entrenched discriminatory and violent attitudes towards individuals and groups based on their sexual orientation and gender identity or gender expression. The situation of lesbian, gay, bisexual and transgender persons is of particular concern, as they remain isolated from the main support networks, live and work in very difficult environments and face violence from the community. There have been commendable attempts to address discrimination against and social exclusion of lesbian, gay, bisexual and transgender persons in the form of a number

[42] See www.unfpa.org/news/new-survey-shows-violence-against-women-widespread-indonesia.

[43] See http://indonesia.unfpa.org/sites/default/files/pub-pdf/2016_SPHPN_%28VAW_Survey%29_Key_Fndings1_0.pdf.

of scattered technical and welfare regulations and initiatives. These include: circular No. 6/X/2015 issued by the head of the national police and stipulating that sexual orientation is one of the main issues related to hate speech; Ministry of Home Affairs regulation No. 27/2017 including transgender persons in the provision of social services; and Ministry of Social Affairs regulation No. 6 (2012) and the Ministry of Culture "Peduli" programme, both of which incorporate lesbian, gay, bisexual and transgender persons as beneficiaries.

84. Discriminatory attitudes and increasingly restrictive laws and regulations relating to expression of sexual orientation and gender identity have contributed to increased stigma and harassment in health-care settings for lesbian, gay, bisexual and transgender persons seeking sexual health care and services, including refusal of admission or services and a lack of comprehensive health services tailored to their needs. Regulations at the national and subnational levels create barriers to access to these services. Moreover, confidentiality is not always guaranteed.

85. Many lesbian, gay, bisexual and transgender persons do not use health services for fear of stigma and rejection, particularly if they fear arrest or breach of privacy and disclosure of their sexuality or gender identity to their family and community. To address this issue, the Ministry of Health has developed training modules and education materials for health personnel.

86. However, the Special Rapporteur heard testimonies and was presented with evidence of violence and discrimination against transgender women, who face extreme forms of violence based on their sexual orientation and gender identity and expression. Transgender women also suffer from harassment under laws relating to public order or immoral conduct, including from law enforcement officials, and legal uncertainty when attempting to obtain identity documents. In health-care settings, such women are forcibly tested for HIV/AIDS, are identified on the basis of their identity papers, which do not reflect their current sex status, and are placed in male wards, where they are exposed to serious violence and abuse.

87. The situation in Aceh Province is particularly alarming, in that a 2014 by-law amended the Penal Code to incorporate certain principles of sharia law, applicable to Muslims and, in certain cases, to non-Muslims. The by-law contains provisions criminalizing consensual, same-sex sexual acts and all sexual relations outside of marriage, and providing for sanctions of up to 100 lashes and up to 100 months' imprisonment for consensual, same-sex sexual acts. Punishments are also imposed against persons who are viewed as not behaving in accordance with such moral principles as dressing in conformity with one's biological sex.

88. The pathologizing of persons based on their sexual orientation and gender identity is extremely worrying, as are the practice of labelling them as mentally ill or as suffering from "psychiatric disorders" that require treatment and statements comparing the "fight" against homosexuality to modern warfare. Such classifications perpetuate prejudice and discrimination and have been used as a pretext for abusive forced treatment, psychiatric evaluation and procedures to change the sexual orientation of individuals, so-called corrective therapies. Such therapies are unacceptable from a human rights perspective, are unscientific and unethical and have serious negative impacts on the mental health and well-being of the persons concerned.

89. The Constitutional Court is currently examining a petition seeking to criminalize consensual, same-sex behaviour and increase penalties for sexual activity out of wedlock. Proposed amendments to the Penal Code include limits on the distribution of contraceptive supplies and on the provision of information about contraception. The amendments, if approved, risk creating additional barriers for women and certain key populations in the realization of their right to health and will be counterproductive from a public health perspective.

Harmful practices: child marriage and female genital mutilation

90. The situation of women and girls, who face compounded forms of discrimination due to their social, cultural and religious backgrounds, is of particular concern. This group includes women and girls who are exposed to harmful traditional practices, such as child marriage and female genital mutilation.

91. In Indonesia, the prevalence of child marriage remains alarmingly high: an estimated 3,500 girls are married every day, with 1 in 7 girls being married before the age of 18 years, with rates as high as 35 per cent in some provinces.[44]

92. Girls living in rural areas, from poorer households and those with limited or no access to education are more likely to be married early. Legislation sets the age for marriage at 21 years for both men and women. There are exceptions to the age limit: girls aged 16 years and boys aged 19 years can marry with their parents' permission. The law includes a clause that allows girls aged under 16 years to marry if their parents obtain a dispensation from local religious or district-level courts.[45] Every year, an estimated 300,000 girls are reported to marry before the age of 16 years.[46]

93. In an attempt to reduce the incidence of premarital sex and alleviate the perceived shame of having an unmarried pregnant daughter and children born out of wedlock, certain authorities are extending dispensations, thereby encouraging underage marriage.

94. Child marriage is not only a violation of girls' basic rights but also has significant health, gender and socioeconomic consequences. Early marriage is often associated with an increased risk of early and frequent pregnancies, with married girls often unable to effectively negotiate safer sex, leaving them vulnerable to sexually transmitted infections, including HIV.[47]

95. The inclusion of child marriage as a priority in the national midterm development plan for the period 2015–2019, and the adoption of several regulations to protect girls from child marriage are commendable. It is important that these measures are effectively implemented, in line with the targets and indicators of the Sustainable Development Goals relating to the elimination of child marriage.

96. Female genital mutilation/cutting, which, according to various definitions, including that used by WHO, includes female circumcision under types I and IV, is widely practised across Indonesia. In the 2013 Ministry of Health basic health survey, it was found that 51 per cent of girls aged between 0 and 11 years had been circumcised.

97. The prevalence of this practice is alarming and the health authorities have issued a regulation barring health professionals from performing the procedure, Ministry of Health regulation No. 1636 (2010). However, this policy development has yet to be widely disseminated. Reports indicate that the medicalization of this harmful practice is extended in the interests of "safer and hygienic" procedure, contrary to WHO regulations.[48] In rural communities, in the past, the procedure was performed by traditional birth attendants, but, more recently, they have been replaced by midwives in this regard.

98. Ministry of Health regulation No. 1636 (2010) contains a number of legal contradictions that risk supporting female genital mutilation. Article 1 of the regulation, for example, discourages the practice, affirming that it has no medical benefit. However, article 2 accepts the practice, outlining that it may be carried out subject to guidelines issued by the council for health and religious consideration. In order to avoid inconsistencies in law and in practice, and to safeguard the rights of women and girls, effective and appropriate measures, complemented by culturally sensitive education and public awareness campaigns, should be taken to abolish female genital mutilation.

99. The practice constitutes a denial of the dignity and integrity of those affected, is based on unacceptable discrimination and violence based on sex, gender, age and other

[44] United Nations Children's Fund (UNICEF), *The State of the World's Children 2016: A fair chance for every child* (2016).

[45] Law No. 1 on marriage (1974).

[46] See www.girlsnotbrides.org/wp-content/uploads/2016/11/UNICEF-Indonesia-Child-Marriage-Factsheet-1.pdf.

[47] UNICEF, "Child marriage in Indonesia: progress on pause". Available from https://www.unicef.org/indonesia/UNICEF_Indonesia_Child_Marriage_Reserach_Brief_.pdf.

[48] World Health Organization (WHO), "Global strategy to stop health-care providers from performing female genital mutilation" (2010).

grounds and often causes severe physical and psychological harm or suffering.[49] The partial or complete removal of the external female genitalia, or the injury of female genital organs, for non-medical or non-health reasons, can lead to multiple immediate and long-term health consequences. The practice denies girls and women the opportunity to make an independent decision about an intervention that has a lasting effect on their bodies and that infringes on their autonomy and control over their lives.

B. Persons living with HIV/AIDS

100. Indonesia has a relatively low prevalence of HIV/AIDS, which, in 2016, affected about 0.4 per cent of the population in the 15–45-years age bracket. However, prevalence remains quite high among certain key populations, particularly men who have sex with men (25.8 per cent), injecting persons who use drugs (28.7 per cent) and transgender persons (24.8 per cent). Over the past few years, the nature of the epidemic has been changing and most new cases of infection are sexually transmitted. According to available data, only 35 per cent of persons living with HIV/AIDS know their status, the coverage of adults and children receiving antiretroviral treatment is quite low (about 13 per cent), and knowledge of HIV prevention among young persons should be improved.[50]

101. An analysis of the epidemic shows that most cases are concentrated in a few provinces, mainly Jakarta, Papua and West Papua Provinces, which are experiencing a generalized epidemic.[51] It is estimated that 2.4 per cent of the general population in Papua Province is living with HIV; the prevalence of HIV is reportedly higher among young persons aged 15–20 years.

102. Over the past decades, there has been serious commitment on the part of the authorities to fight the spread of the infection and to provide access to testing and treatment for persons living with HIV/AIDS, including by addressing mother-to-child transmission through targeted prevention and treatment programmes. However, while HIV testing in Indonesia has substantially increased overall, numbers are still low and coverage for antiretroviral treatment is among the lowest in the region.[52]

103. Since 2009, total government expenditure on HIV/AIDS has been increasing: a situation which should be commended. However, a large portion of that funding still comes from international partners, including the Global Fund to Fight AIDS, Tuberculosis and Malaria, raising concerns about the sustainability of HIV/AIDS policies and programmes. Funding at the district level is deemed to be insufficient, restricting access to treatment and services.[53]

104. The Special Rapporteur was informed that the National AIDS Commission will cease to exist as of 2018 and that its functions and responsibilities will be absorbed by the Ministry of Health. The authorities should set up an independent body to monitor the situation, implement and coordinate programmes, and engage with key populations. The body should be provided with sufficient resources to effectively combat the spread of AIDS and achieve the goal of its elimination by 2030.

105. Existing normative, policy and institutional frameworks act as serious barriers to access to treatment and services, hindering the effectiveness of the HIV response.

[49] Committee on the Rights of the Child, general comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health, para. 9; Committee on the Elimination of Discrimination against Women, general recommendation 19 (1992) on violence against women, para. 20; joint general recommendation No. 31 of the Committee on the Elimination of Discrimination against Women/general comment No. 18 of the Committee on the Rights of the Child (2014) on harmful practices.

[50] See www.unaids.org/en/regionscountries/countries/indonesia/.

[51] National AIDS Commission, 2014 Report, p. 16. Available from www.unaids.org/sites/default/files/country/documents/IDN_narrative_report_2014.pdf.

[52] United Nations Office on Drugs and Crime (UNODC), *Country Programme 2017–2020: Indonesia*, p. 22.

[53] UNAIDS, "Indonesia report NCPI", 2013.

Homosexuality and sex work are criminalized at the national and provincial levels, and most by-laws and local regulations contain provisions that criminalize non-disclosure, exposure and transmission, and that impose mandatory testing. This situation is incompatible with the obligations arising from the right to health and other human rights, as it is discriminatory on the basis of health status and infringes upon the rights to privacy, to autonomy and to refuse treatment.

106. The Special Rapporteur was informed about ongoing discussions in the context of article 481 of the draft revised Penal Code reform criminalizing the distribution of contraceptives, including condoms, unless it is done by qualified health officials. This measure would have a negative impact on prevention programmes, since outreach workers, many of whom are not qualified health officers, would no longer be able to perform this important task.

107. Reports and testimonies gathered during the visit indicate that stigmatization and discrimination, particularly in health-care settings, are major barriers preventing key populations from obtaining access to treatment and services. Consequently, such populations tend to avoid health services. While the adoption of health-related policies and programmes targeting key populations is commendable, it does not offset the impact of criminalization, which is a serious barrier to the enjoyment, by those at risk, of the right to health, and which drives them away from the services they need and increases health-related risks for society as a whole.

108. Moreover, there is a societal misconception associating HIV/AIDS with immoral behaviours, which suggest low levels of understanding among the general public of HIV/AIDS risk behaviours. The United Nations Educational, Scientific and Cultural Organization (UNESCO) has criticized the way HIV transmission is depicted in some school textbooks based on myths and widespread misconceptions.[54]

109. More effort is needed to effectively reach out to those most at risk and to ensure access to good quality, evidence-based services, including by working in close partnership with key affected populations. Evidence-based public awareness, education and information campaigns are necessary to address widespread misconceptions about HIV/AIDS.

110. The situation in Papua, where there is a generalized epidemic and infection rates are the highest at the national level, is of particular concern. The Special Rapporteur notes specific HIV/AIDS policies in Papua, where HIV tests are offered to all users of health services, regardless of their symptoms, while in other provinces, they are only offered to members of high-risk populations. Despite these and other commendable attempts, ethnic Papuans are currently twice as likely to have HIV/AIDS than the rest of the population, and rates of infection are on the rise in this part of the country. The situation in Wamena, Timika and Nabire Regencies shows that the epidemic is moving from coastal areas to the highlands, where most ethnic Papuans live, often in remote areas.

111. Ethnic Papuans face important challenges when it comes to awareness, testing, treatment and health-related services, both in terms of access but also of effectiveness of the response, given adverse historical, socioeconomic and cultural factors. Women are at particular risk in this context, where new infections are mostly sexually transmitted. This critical situation deserves special attention and efforts from all stakeholders to build trust among service providers and users, but also to scale up investment in the health sector and to enhance access to treatment and services in a culturally sensitive manner.

112. More effort is required to actively reach out to those populations, both as a preventive measure and also to ensure effective access to health services. Age-appropriate, evidence-based, educational modules on HIV/AIDS transmission and prevention should be included in the school curricula.

113. Target 3.3 of the Sustainable Development Goals is aimed, among other things, at ending the AIDS epidemic by 2030. In order to achieve this target and to continue leading

[54] See http://unesdoc.unesco.org/images/0024/002473/247396E.pdf.

efforts in the region, Indonesia needs to promote the necessary normative and societal changes to achieve zero discrimination, particularly in health-care services.

C. Persons who use drugs

114. Indonesia has not traditionally been a major producer of illicit drugs but has become a key transit country for the trafficking of such substances.[55] Drug use has steadily increased in recent years, with synthetic drugs, including methamphetamine, ecstasy and, to a lesser extent, amphetamine, becoming increasingly available.

115. National data show that, in 2015, more than 4 million persons (about 2.2 per cent of the population) used drugs.[56] Moreover, HIV prevalence among persons who inject drugs is currently alarmingly high. Between 2009 and 2014, HIV prevalence among persons who inject drugs rose from 27 per cent to 39.7 per cent, making Indonesia the country in the region with the second highest HIV rate among this population group.[57]

116. Indonesia is party to the Single Convention on Narcotic Drugs, 1961, the Convention on Psychotropic Substances, 1971, and the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, and has adopted a punitive approach towards drug use and supply in an attempt to deter use and curb trafficking. Penalties for drug-related offences are quite severe, including the death penalty, which is employed as a last resort in cases of drug trafficking and after domestic remedies have been exhausted and has been used on several occasions since 2013. Overuse of incarceration for drug-related offences leads to overcrowding in prisons and to a consequent deterioration of the conditions of detention.

117. Article 127 of law No. 35 (2009) criminalizes drug use and the possession of small quantities of illicit drugs for personal use and fails to make a distinction between casual users and those who may have dependency problems. In a positive step, law No. 35 provided for mechanisms to divert persons who use drugs away from the prison system and towards treatment. However, articles 55 and 128 of the law also established the compulsory registration, self-reporting and reporting of persons who use drugs.

118. The criminalization of drug use, together with compulsory reporting and rehabilitation, only generate more discrimination, violence and exclusion. Criminalization has not proved to be an effective way of curbing drug abuse or drug trafficking: it drives individuals away from the health services that they need, seriously undermining public health efforts.

119. While the efforts made to address drug use through non-custodial measures should be recognized, granting criminal courts jurisdiction over a public health issue can lead to forms of coercive treatment. Drug use should not be a criminal offence and restorative measures should be put in place to address such behaviours outside the criminal justice system, particularly for adolescents and young persons.

120. Drug-abuse services and treatment are mostly provided by the public sector but the relevant authorities have acknowledged challenges in providing adequate and good quality services. Since 2002, Indonesia has implemented a basic harm-reduction policy, including needle-syringe exchange programmes and opioid substitution treatment. Additionally, public, community-based, rehabilitation programmes have been established and are

[55] UNODC, *Country Programme 2017–2020 Indonesia*, pp. 12–14. Available from www.unodc.org/documents/indonesia/publication/2017/UNODC_Country_Programme_2017_-_2020.pdf.

[56] See http://www.iosrjournals.org/iosr-jhss/papers/Vol20-issue4/Version-5/H020454246.pdf, http://iosrjournals.org/iosr-jhss/papers/Vol20-issue8/Version-2/A020820103.pdf and http://bnn.go.id/_multimedia/document/20161208/survei_2015_-_english_version_isbn_final_cetak.pdf.

[57] UNODC, *Country Programme 2017–2020 Indonesia*, p. 21. Available from www.unodc.org/documents/indonesia/publication/2017/UNODC_Country_Programme_2017_-_2020.pdf.

available in priority areas that are considered to be at risk based on HIV infection rates and the number of persons who inject drugs reported therein.

121. The Special Rapporteur visited health centres with specific programmes and services for persons who use drugs. Such structures provide counselling and harm-reduction services but are few in number and do not cater for the needs of specific populations, such as adolescents and young persons. Reportedly, social discrimination is an important barrier for many persons who use drugs wishing to access drug-dependency treatment and services and HIV prevention, treatment, and care. Drug use is an illegal activity, therefore, a positive drug test and/or possession of needles and syringes can attract attention from law enforcement officials.[58]

122. The interaction of health services with persons who use drugs in Indonesia is mostly based on law enforcement and does not respect some of the basic elements of the right to health, including informed consent and the right to refuse treatment. Adequate health services should be put in place based on informed consent and the right to refuse treatment, a key element of the dignity and autonomy of those individuals affected. More investment in prevention, education and information programmes on drug use is needed.

V. Conclusions and recommendations

123. **There are real opportunities and a genuine commitment to achieve the progressive realization of the right to health in Indonesia. The country has been at the forefront of the global movement towards the Sustainable Development Goals and the 2030 Agenda, and it is now leading the way towards universal health coverage, a key element in developing an equitable and sustainable health-care system.**

124. **This is an illustration of political will and a sign that the Indonesian leadership understands the intrinsic link between sustainable and inclusive development and the need to invest in the right to health, including in an equitable health system. For this ambitious goal to be reached, gaps and challenges relating to the enjoyment of the right to health need to be identified and addressed in a comprehensive way.**

125. **The public authorities need to step up efforts to address structural and systemic issues, both in law and in practice, to make sure that they are not tempted merely to address issues that can be resolved easily and to make sure that no one is left behind.**

126. **The right to health can only be fully realized through the enjoyment of the underlying and social determinants of health, which requires the design and implementation of cross-sectoral policies and programmes that focus not only on life-saving and other biomedical interventions but also on broader socioeconomic, cultural and environmental factors.**

127. **Health policies, programmes and services should be guided by a human rights-based approach, with strong emphasis on the principles of equality, non-discrimination, transparency, participation and accountability.**

128. **The Special Rapporteur recommends that the authorities of Indonesia:**

(a) **Consider ratifying the Optional Protocols concerning individual communications procedures of the international human rights treaties, and extending a standing invitation to the special procedures of the Human Rights Council;**

(b) **Promote the adoption of a law against all forms of discrimination, and introduce public awareness-raising campaigns and education programmes to combat discrimination;**

(c) **Strengthen the health-care system and guarantee adequate, equitable and sustainable financing by increasing *national budget allocations for health, and* continue improving the availability and accessibility of health services in remote**

[58] Ibid., p. 22.

regions, with particular focus on primary care, the role of general practitioners, and the situation of *Adat* communities, including ethnic Papuans;

(d) Ensure that a solid health information system is in place to generate quality national data and statistics for the analysis of gaps in and for the design, implementation, monitoring and review of health-related policies and services;

(e) Address maternal and under-5 mortality, including by referring to the WHO Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) and the technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce and eliminate preventable maternal and under-5 mortality and morbidity (A/HRC/21/22 and Corrs. 1–2 and A/HRC/27/31);

(f) Respect, protect and fulfil the right to health of women and girls by removing barriers to their sexual and reproductive rights, ending the criminalization of abortion and ensuring access to abortion services, and providing sexual and reproductive health information, services and goods, particularly comprehensive, age-sensitive and inclusive sexual education in secondary schools;

(g) Ensure comprehensive protection for women against all forms of gender-based violence by addressing, without delay, the remaining gaps in legislation and in practice, in order to ensure substantive equality and women's enjoyment of the right to health and related rights;

(h) Establish an independent national body for HIV/AIDS monitoring and prevention, with a strong mandate and the resources necessary to enable it to perform its functions, in consultation with key stakeholders;

(i) Remove all legal provisions criminalizing and stigmatizing persons living with HIV/AIDS, including those that criminalize homosexuality, sex work, and HIV/AIDS non-disclosure, exposure and transmission;

(j) Guarantee non-discrimination against persons living with HIV/AIDS in the health-care sector by ensuring that health services, materials and information are available, accessible, acceptable and of good quality for all key populations, and that health workers are properly trained and equipped;

(k) Address without delay the HIV/AIDS situation in Papua by guaranteeing access to testing, treatment and culturally sensitive health-related services, particularly for young persons and women, and build trust among service providers and users;

(l) Abolish the death penalty for drug-use offences, promote a non-punitive approach to drug-use policies and programmes outside the criminal justice system and expand services for persons who use drugs, particularly adolescents and young persons, based on scientific evidence and with full respect for their dignity, autonomy and basic rights;

(m) Adopt modern mental health policies and services with a view to mainstreaming them into the general health system and community support services, and launch a comprehensive reform of the mental health-care system in order to optimize investments and move towards community-oriented services based on the principles of non-discrimination, participation and respect for the dignity and rights of users.